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Treatment of Duodenal Ulcer and Functional Bowel Disease with Kolantyl, A New Antispasmodic Compound

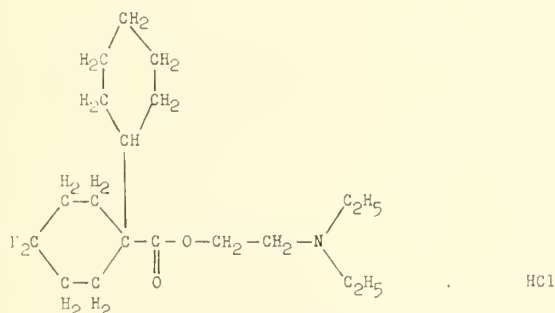
PRELIMINARY CLINICAL NOTES

BEN N. MILLER, M. D.

The natural alkaloids of belladonna have long been employed not only for the relief of functional bowel disease but also as an adjunct in the treatment of duodenal ulcer. Unfortunately, the usefulness of these drugs is somewhat limited by the side effects which are commonly produced.^{1,2} Recently, a new post-ganglionic parasympathetic blocking agent that has been shown to be more selective in its action than atropine and related alkaloids has been described.³ It has been designated as Bentyl Hydrochloride† and ‡Bentyl Hydrochloride is the trademark of the Wm.

S. Merrell Company of Cincinnati, Ohio for its brand of dicyclomine hydrochloride.

may be represented by the following chemical structure:



diethylaminocarbethoxydicyclohexyl hydrochloride

Pharmacologically,³ a concentration of 1:10,000,000 of Bentyl relaxes the isolated rabbit intestine in which spasm has been induced by acetylcholine. This is comparable to the relaxation obtained with atropine sulfate in concentration of 1:80,000,000. *In vivo*, maximal relaxation of an intestinal loop or pouch can be produced in the dog with doses of 2 mg./Kg. of Bentyl³ which is comparable to that produced by 0.1 mg./Kg. of atropine sulfate.⁴ In the case of the isolated dog ureter, 5 mg. of Bentyl per 100 cc. of

bath was comparable to 25 mg. of atropine sulfate in relaxing spontaneous contractions,³ indicating that in this case the milligram potency of Bentyl was actually greater than that of atropine.

The characteristic atropine-like effects on the eye and mouth are produced only when extremely large doses of Bentyl are used. Specifically, the dose of Bentyl that dilates the pupil of 80 per cent of the tested mice is 4 mg. parenterally in an 18 to 20 Gm. mouse but a dose of only 0.008 mg. of atropine produces a similar effect.³ When doses of 5 mg./Kg. of pilocarpine are used to stimulate salivary flow in the rabbit, intramuscular doses of 48 mg./Kg. of Bentyl or of 0.15 mg./Kg. of atropine are needed for inhibition.³ The usual clinical dose of Bentyl is 10 mg. (almost 35 times the usual dose of 0.3 mg. of atropine). Table One illustrates the expectation that Bentyl would produce those atropine-like effects in which the milligram potency of Bentyl is 1/35th or more that of atropine (relaxation of the gastrointestinal tract, urinary tract) but not those in which the milligram potency is less than 1/35th that of atropine (dilation of the pupils, drying of the mouth).

In animals Bentyl is relatively nontoxic. The LD₅₀ for oral administration in mice is 625 mg./Kg.³ In human subjects Hock has administered single oral doses of Bentyl Hydrochloride of 130 mg.⁵ This is 13 times the usual clinical dose and even at that level side effects did not always occur (although a poorly defined "jerking sensation" of the head is described in one patient). Using oral doses of 10 mg. and 20 mg. the writer has observed no side effects to Bentyl in over 100 cases, which is consistent with the published reports of Hock,⁵ Hufford,^{6,7} Chamberlin,⁸ and McHardy.⁹

CLINICAL RESULTS WITH BENTYL

Hock,⁵ Hufford,⁶ and Chamberlin⁸ all reported a high incidence of symptomatic relief following oral Bentyl therapy in groups of patients consisting mostly

of those suffering from functional diseases of the colon. McHardy and his associates⁹ compared 246 patients suffering from duodenal ulcer (200 cases) and pylorospasm (46 cases) treated with Bentyl, Banthine,[‡] atropine, and placebo therapy. In general, they found both Bentyl and Banthine to be effective in the majority of cases and both were significantly more effective than atropine or placebo therapy. There were some cases, however, that did not respond to any of the single drugs employed. The author's experience in over 100 cases treated with simple Bentyl Hydrochloride is entirely consistent with the published cases here cited.

RATIONALE FOR KOLANTYL THERAPY

Therapy with Bentyl alone, while effective in the majority of cases, was not completely effective in all cases of peptic ulcer. The question then arose whether it would be better to increase greatly the Bentyl dosage until side effects similar to those commonly observed with Banthine might occur, or to combine the antispasmodic Bentyl (in well tolerated dosage) with antacids and other anti-ulcer agents in an attempt to control most of the causative or contributing factors present. The latter course was adopted and the compound selected was designated as Kolantyl.[°] Each tablet contained the following:

Bentyl Hydrochloride	5 mg.
Aluminum Hydroxide Gel	400 mg.
Magnesium Oxide	200 mg.
Sodium Lauryl Sulfate	25 mg.
Methylcellulose	100 mg.

Bentyl Hydrochloride was included as an antispasmodic, aluminum hydroxide gel and magnesium oxide as antacids, and methylcellulose as a synthetic mucin to coat the gastric and duodenal mucosa. Of particular interest was the inclusion of sodium lauryl sulfate to inactivate both lysozyme and pepsin. The importance of lysozyme as an etiologic or contributing factor in peptic ulcer is and probably will continue to be a somewhat controversial question. It seems clear, however, that there is an increase in the tissue lysozyme concentration surrounding active peptic ulcers as compared with healed lesions.¹⁰ Lysozyme can cause experimental lesions of the gastrointestinal tract in animals.^{11,12,13} Sodium lauryl sulfates inhibit lysozyme activity.^{14,15} Antilysozyme therapy alone is effective in at least some resistant cases of peptic ulcer,¹⁶ and antilysozyme therapy even seems to aid in wound healing outside the gastrointestinal tract.¹⁷

CLINICAL RESULTS WITH KOLANTYL

Table Two indicates that in the author's series of patients, duodenal ulcer responded regularly to the

[‡]Banthine is the trademark of G. D. Searle & Co., of Chicago, Illinois for its brand of methantheline bromide.

[°]Kolantyl is the trademark of The Wm. S. Merrell Company of Cincinnati, Ohio.

oral administration of two Kolantyl tablets four times daily. Similar findings have been reported by Huford.⁷ Because of the observation that duodenal ulcer responded better to Kolantyl than to simple antispasmodic therapy, it was also tried in functional bowel disease. Table Two indicates that preliminary findings in this condition were also encouraging. The only frank failure was in a case of herniation of the gastric mucosa through the pylorus which produced nausea, vomiting, and regurgitation that did not respond to any type of antispasmodic therapy.

The 24 patients treated with Kolantyl suffered from 11 different symptoms which occurred in the group a total of 103 times, as indicated in Table Three. In 15 cases Kolantyl was compared with other antispasmodics (Barbidonna^{°°} and Banthine) as indicated in Table Four. In 14 instances Kolantyl was more effective; in 1 case Banthine was more effective.

As in the earlier series of Bentyl cases, side effects did not occur during Kolantyl administration. Up to the present time the longest duration of therapy with Bentyl has been 14 months (total of 1,200 capsules, i.e., total dose of 12.0 Gm.) and with Kolantyl it has been 6 months. In general, prolonged therapy has not been required in most cases but there are 4 patients who have been on Bentyl continuously for a year or longer.

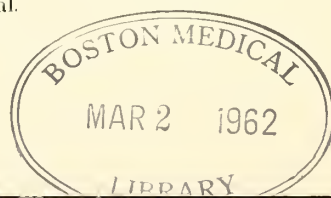
The clinical response to Kolantyl may be illustrated by the case of Mrs. L. B. K.:

This patient was first seen on August 14, 1946 at the age of 64. She complained at that time of generalized weakness plus recurring epigastric pain. This was described as a gnawing sensation coming one to two hours after meals. It was relieved by food. This had persisted for a number of years, and as far back as June 4, 1920 she was subjected to appendectomy and duodeno-duodenostomy. The operative report (Columbia Hospital) describes an ulcer one-quarter inch in diameter on the superior surface of the duodenum one-half inch from the pylorus.

On the initial examination, Mrs. L. B. K. was negative except for a vertical right upper abdominal scar and some epigastric and upper abdominal tenderness. Symptoms were controlled for the next three years by dietary measures plus belladonna which was required only occasionally.

On September 20, 1949 she was admitted to the Providence Hospital following exsanguinating blood loss from the gastrointestinal tract. Following a prompt response to the usual emergency procedures, x-ray studies were made on September 26, 1949. The stomach and esophagus were normal, but there was

^{°°}Barbidonna is the trademark of Vanpelt & Brown, Inc. of Richmond, Virginia for its brand of hyoscyamine, atropine, scopolamine, and phenobarbital.



a deformity of the duodenal bulb, which was irritable, and an ulcer niche appeared within it (Figure One).



On January 3, 1951 the patient refused further Bantline therapy because of the side effects and she was started on Kolantyl, two tablets after each meal and at the hour of sleep. With this medication and a moderate limitation of diet the patient was relieved promptly from her epigastric pain and tenderness. X-rays taken on April 19, 1951 showed the residual deformity of the duodenal cap from the previous duodenal ulcer but no ulcer niche could be identified and there was no evidence of spasm (Figure Two).



The patient was put on strict dietary management plus aluminum hydroxide gel plus Barbidonna. In spite of treatment she continued to have considerable pain and on March 23, 1950 the ulcer niche was still present on x-ray examination.

Banthine, 100 mg. every six hours by mouth, was then substituted for Barbidonna. She objected to the side effects notably dryness of the mouth and throat and interference with vision. Pain was intermittent during Banthine therapy.

On August 1, 1951 the patient was still free from symptoms.

TABLE ONE	
SELECTIVE ACTION OF BENTYL	
ACTION	COMPARISON OF MG. POTENCY WITH ATROPINE
Relaxation of isolated dog ureter	About 25 times that of atropine
Relaxation of isolated rabbit intesting	About 1/8 that of atropine
Relaxation of loop of dog intestine <i>in vivo</i>	About 1/20 that of atropine
THE CLINICAL DOSE	
OF BENTYL (10 MG.) is almost 35 times that of Atropine (0.3 mg.)	
Depression of salivary secretion	About 1/300 that of atropine
Dilation of pupil	About 1/500 that of atropine

TABLE FOUR
COMPARISON: KOLANTYL VS. OTHER ANTISPASMODICS

No Previous Antispasmodic Therapy	BARBIDONNA		BANTHINE		DONNATAL	
	Less Effective than KOLANTYL	More Effective than KOLANTYL	Less Effective than KOLANTYL	More Effective than KOLANTYL	Less Effective than KOLANTYL	More Effective than KOLANTYL
A.W.B. B.H.B. F.E.B. H.F.G. J.C.G. J.E.L. N.H.S. H.S.T. H.U.	J.M.A. G.D.B. T.E.B. S.E.C. J.E.H. B.N.M. O.W.M. M.S.S.		S.E.C. L.H. L.W.I. L.B.K. E.M.MeW. C.P.	C.W.R.	M.S.	
TOTALS:	9	8	0	6	1	0

N.B. 24 patients are listed 25 times since S.E.C. was tried on two other antispasmodics and is listed, therefore, twice.

SUMMARY

The pharmacologic and clinical reports show that Bentyl Hydrochloride is an improved substitute for atropine for gastrointestinal spasm without dilating the pupil or drying the mouth. This has been confirmed in a series of over 100 patients. This work has been extended to indicate that the drug Kolantyl (Bentyl, aluminum hydroxide gel, magnesium oxide, sodium lauryl sulfate, and methyleellulose) is well tolerated and even more effective than plain Bentyl in the treatment of duodenal ulcer and functional bowel disease. It compares favorably with the other potent natural and synthetic parasympatholytic agents. The efficacy of Kolantyl may be due in large measure to the inactivation of lysozyme by sodium lauryl sulfate.

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Rheumatic Carditis

JOHN A. BOONE, A.B., A.M., M.D.

Professor of Medicine

Medical College of South Carolina

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Since the ability of rheumatic fever to damage the heart is almost the only reason for regarding it as a serious disease, some of the important features of this inflammation will be reviewed.

It is an interesting bit of medical history to Southerners that the first publication describing the connection between rheumatic fever and rheumatic heart disease was written by a native of Charleston, S. C., William Charles Wells. Wells' family were unfortunately Tories at the time of the American Revolution, and fled to England where Wells studied medicine and eventually became a prominent London physician. In 1812 his paper⁽¹⁾ describing the ability of rheumatism to affect the heart appeared. It is remarkable that at that time the stethoscope had not yet been invented.

The importance of carditis as a manifestation of rheumatic fever is illustrated by its being the leading cause of death from heart disease before middle age. Coombs² in 1924 observed 100 consecutive cases of rheumatic fever. Of these, 59 showed evidence of heart involvement in the first attack, and this increased to 75 with further observation. In 1942 Rowntree³ reported that of the first 2,000,000 selective service applicants in World War II, all between the ages of 21 and 36, 5% were rejected because of cardiovascular defects. When these rejected individuals were reexamined by experts, half of them were found to have rheumatic heart lesions. That even those figures failed to reflect the true incidence of rheumatic heart disease will be demonstrated later.

For a long time it has been the general belief that rheumatic heart disease did not occur in the tropics, and was infrequent in the Southern states. This was the basis some years ago for the removal of rheumatic children from New York to Puerto Rico as a therapeutic measure. Since then, however, it is becoming apparent that there is not the sharp geographical division heretofore supposed. When the author first came to Charleston in 1937, he was assured that he would see little rheumatic heart disease, but instead he has seen a great deal of it. Physicians stationed in the tropics during World War II saw much more rheumatic fever and its sequelae, both in their own troops and the native populace, than they had been led to expect. Moreover, Chavez⁴ in 1942 reported a surprisingly high incidence of rheumatic heart disease in Mexico.

It may be that the incidence in different climates is

closer than has ever been suspected. The thinner and less urbanized population in the South and the tropics must have an effect on impressions of incidence. In large cities, more cases come under the care of large clinics. In rural communities, medical examination is sketchy and diagnosis is poorer. Few people stop to think that the population of South Carolina is less than that of metropolitan Boston, or of Texas less than that of New York City, and that the ratio of physicians to population is similar. From experience in Charleston, the author would almost be willing to wager that the state of South Carolina would not be far below Boston in total rheumatic heart disease content. Another striking feature of experience in Charleston is the extremely low incidence of hemolytic streptococcus infection. During the past year the bacteriology laboratory in Charleston has isolated less than a half dozen organisms. We have seen far more fresh cases of rheumatic fever and rheumatic heart disease than that. This is an interesting finding in view of the increasing tendency in many quarters to view the hemolytic streptococcus as the cause of rheumatic fever. It would suggest that possibly, whatever the cause of rheumatic fever, respiratory infections with this organism may be the most common illness severe enough to "trigger" the rheumatic state into activity.

There seem to be real differences in the clinical picture of rheumatic fever in the northern states and in the South. Among 225 cases studied in Boston by the author⁵ only 4% lacked a history of clinical rheumatic fever or chorea. In our own clinic in Charleston the figure would be nearer 50% in cases with known rheumatic heart disease. This seems to indicate a tendency to a more insidious subacute form of the disease in the south. Certainly we very rarely see subcutaneous nodules.

There is no question that diagnosis of rheumatic heart disease as compared to other disease is poor in the hands of the average physician who has not had intensive training in internal medicine. And the widespread tendency to call all unexplained fevers malaria does not help the accurate diagnosis of rheumatic fever in the South. The first great American cardiologist, Austin Flint,⁶ made the following statement in 1862, when he was 50 years old, in reference to the murmur of mitral stenosis: "It is only within the last few years that I have discriminated between these murmurs When the auscultator has learned to distinguish it, he will not be long in finding it if he be in the way of seeing a moderate number of cases of disease of the heart." That Flint's words still apply is shown by a 1942 report by Delaney and others⁸ who reported on 45,000 World War II air force cadets. All these had been screened by from 1 to 12

previous physical examinations, but 100 were found to have rheumatic heart murmurs. A breakdown of their figures indicates that the relatively harmless murmur of mitral insufficiency had not often been ignored, but the much more serious lesions of aortic insufficiency and stenosis and mitral stenosis had been missed in 90%:

Mitral insufficiency	10
Mitral stenosis	38
Aortic insufficiency and/or stenosis	46
Combined aortic and mitral lesions	6
<hr/>	
Total	100

The symptoms of rheumatic carditis, active or inactive, are remarkably few and of little use in diagnosis except as they refer to the congestive phenomena of heart failure. The accurate evaluation of physical signs and laboratory findings are all-important both in diagnosis and such imperfect prognosis as we are able to make.

In active carditis the pulse rate may be higher than the usual 10 points per degree rise. Arrhythmias, especially true dropped beats from heart block, or showers of extrasystoles, may appear. Systolic murmurs must be evaluated more by their loudness and their persistence after the acute illness. Aortic diastolic murmurs may appear very early in the acute illness, but the interpretation of diastolic noises in the mitral area is best left until the quiescent stage, for they are usually very misleading. Friction rubs synchronous with the heart beat indicate pericardial involvement. Enlargement of the heart may indicate either myocardial weakness or pericardial effusion, and this distinction may be difficult. Congestive failure may occur in severe cases and must be distinguished from tamponade from pericardial effusion. One peculiarity of such heart failure in younger children is that the venous engorgement, liver enlargement and ascites frequently overshadows either the peripheral or pulmonary edema so characteristically associated with heart failure in older children and adults. The electrocardiogram may show varying degrees of heart block or the characteristic changes of pericarditis. In the author's experience, electrocardiographic evidence of active carditis is extremely rare in the routine follow-up of cases, and one must always resist the temptation to read too much into routine electrocardiograms.

Inactive carditis is assumed when joint pains and fever have gone and the white blood count, sedimentation rate and electrocardiogram have returned to normal. But we know of many cases where all these criteria are satisfied, but the development of valvular deformity progresses inexorably nevertheless. Sometimes the general impression that the child "is not doing well" is more valuable than laboratory tests. The diagnosis of supposedly inactive rheumatic carditis depends mainly on the recognition and interpretation of murmurs.

Systolic murmurs are most commonly heard, usually in the apical region. Faint systolic murmurs near the base of the heart are most difficult to evaluate. Many may be functional; some may arise from a harmless venous hum in the neck, which can easily be checked. As mentioned above, aortic diastolic murmurs may arise during the first attack of rheumatic fever. The diastolic murmur of mitral stenosis probably requires at least three years after the first involvement to develop. The evaluation of apical mid-diastolic murmurs and third heart sounds is a vexing question. The mid-diastolic murmur was once called "the childhood type of mitral stenosis murmur." But no one can reliably distinguish between murmur and third sound. In one study⁷ of true mid-diastolic murmurs diagnosed by experts, 60% later showed the typical presystolic crescendo murmur of mitral stenosis, 40% subsequently disappeared. The simple grading of systolic murmurs from I to IV on the basis of relative loudness as advocated by Dr. Samuel Levine has much to recommend it. A Grade I murmur in itself is insufficient evidence of heart disease. Grades II to IV are increasingly indicative of organic disease.

As to specific valves, the pulmonic is almost never involved in rheumatic fever. Tricuspid involvement is almost always associated with mitral, and virtually impossible to distinguish from it clinically. Aortic insufficiency may first appear as a very faint high-pitched blowing diastolic murmur best heard down the left sternal border. A quiet room and a diaphragm type stethoscope are often necessary for its recognition. The diastolic blood pressure is normal at this stage. Aortic stenosis usually appears years later, in middle age and beyond, sometimes after long-standing aortic insufficiency. Often no murmur at all, or an apical systolic will have been present previously. A systolic thrill over the aortic area with the characteristic plateau pulse makes the diagnosis. The presence of aortic insufficiency cancels the plateau pulse.

Mitral stenosis in a regular heart is reliably diagnosed only by the accurate recognition of the long rumbling apical diastolic murmur with presystolic crescendo accentuation. It is the hardest murmur of all for the physician to learn to recognize correctly. The average physician either misses it entirely or confuses it with a systolic murmur. The better trained younger ones hear it too often. The subsidiary signs of accentuation of the first apical heart sound and second pulmonic sound are often helpful. X-ray evidence of auricular enlargement or EKG signs of auricular hypertrophy may be of aid, but not until the lesion is pretty far advanced. Eventually auricular fibrillation occurs in most, when the murmur loses its presystolic accentuation, and a low pitched early-to-mid-diastolic only is left.

The prognosis is good in most cases for the acute phase of carditis. A few fulminating cases go steadily downhill, a few more subacute cases succumb after a few years. In the inactive phase, prognosis seems best based on a 5 to 10 year observation period after the

first occurrence of rheumatic fever. In general, the resistance of the heart proved during this period will hold good for the future, but all cases should be followed at intervals the rest of their lives. Bacterial endocarditis is always a potential hazard, but can now be very successfully treated with antibiotics if early diagnosis is made.

Treatment in the acute phase is in general that of the rheumatic fever. It seems to be becoming general knowledge that cortisone and ACTH have no influence on the cardiac lesion, and this has certainly been our experience. If heart failure develops, digitalis should be tried—in many it helps. Diuretics are always useful. In the subacute cases, prolonged bed rest for many months is frequently rewarded by amazing degrees of recovery of heart function. In the chronic type, protection against infection and physical strain should be encouraged. Surgical correction of mitral stenosis is rapidly becoming a standardized procedure, and doubtless other valvular disease will also become amenable. Treatment of heart failure is standard.

There are certain public health aspects of rheumatic heart disease that deserve to be emphasized. There is

just as much justification for sanatoria for prolonged bed care of subacute rheumatic heart disease as there ever was for tuberculosis. Almost no such facilities now exist, and a few would suffice. Case finding activities are just as comparable. As x-ray is necessary in the diagnosis of tuberculosis, so the trained ear is necessary for the diagnosis of rheumatic heart disease. Already a beginning is being made in this direction at three demonstration centers set up by the U. S. Public Health Service, one of them in Charleston. It is hoped that this activity will continue to expand and be supported by physicians.

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Painful and Painless Anorectal Lesions*

By

LEON BANOV, JR., M. D.
Charleston, S. C.

From a practical standpoint there are two chief symptoms of anorectal diseases that make the patient seek medical care: bleeding and pain. The history of bleeding from the rectum makes it mandatory for the physician to search for the cause of the bleeding. The importance of rectal bleeding has been emphasized again and again in the literature, and rightfully so. To determine the source of the bleeding the physician depends on digital examination, sigmoidoscopy, and roentgenography.

The other important symptom of anorectal diseases is pain. It is often pain, and pain alone, that causes the patient to go to the physician for diagnosis and treatment. Often before arriving at the physician's office, the patient, influenced by newspaper and magazine advertisements, already has employed various forms of self-medication with transient and dubious benefit. The patient needs immediate and definitive relief from pain. To treat the patient properly, the physician must make an accurate diagnosis by obtaining a full history and making a complete examination, using, if necessary, an anesthetic agent in order to examine the extremely painful anorectal region.

A consideration of anorectal lesions based on the presence or absence of pain has been of great practical

value to the writer. Because it may be of value to others, this report is presented. The anorectal lesions are considered as to whether they are painful or painless; a few remarks are made about each. The listing is not intended to be academically so complete as to include the unusual or rare lesions. The classification is presented as a practical clinical aid in the consideration of anorectal lesions.

ANORECTAL LESIONS

PAINFUL	PAINLESS
Cryptitis	Polyp
Papillitis	Carcinoma
Anal fissure	Lymphogranuloma
Perirectal abscess	venereum
Fistula	Syphilis
Hemorrhoids	Granuloma inguinale
Pruritus ani	Tuberculosis

PAINFUL LESIONS

Cryptitis and Papillitis

While pain is the usual complaint with cryptitis, an inflammation of the crypts of Morgagni, the degree of discomfort varies from a dull aching sensation to an acute sharp pain. The diagnosis, made by digital examination and anoscopy, reveals small depressions and areas of tenderness in the rectum, and often some

*From the Department of Surgery of the Medical College of the State of South Carolina and Roper Hospital.

spasm of the anal sphincter. On anoscopy, the diseased crypt will admit the tip of a blunt hook whereas the normal crypt seldom will do so.

There are many opinions regarding the significance of cryptitis. Some regard cryptitis as the initial factor in the development of fissures, abscesses and fistulae. Others consider cryptitis as a cause of pruritus ani. Many hold that cryptitis is too often overlooked as a focus of infection. Buié¹ believes that hemorrhoids are commonly initiated by infection admitted thru these Morgagnian crypts.

Most often found with cryptitis is papillitis, an inflammation of the anal papillae. Following infection, the papillae undergo hypertrophy and sometimes protrude to produce spasmodic pain during and after defecation. Diagnosis is made by feeling the firm teat-like projections on digital examination and seeing the reddened and edematous papillae on anoscopy.

The treatment of papillitis and cryptitis is palliative and/or surgical. Palliation involves the use of an antibiotic (aureomycin, chloromycetin, or terramycin) and hot Sitz baths. The operative treatment consists of the removal of the involved crypts and papillae.

Anal Fissure

Though the anal fissure, a benign ulcerous lesion of the anal wall, is of comparatively minor pathological importance, from the clinical point of view it is one of the most important anal lesions. It is a common cause of rectal pain. It is frequently misdiagnosed and often inadequately managed. The usual history is one of neglect—for weeks, or months, or often years, of pain recurring after periods of relative freedom from pain. The pain of anal fissure is paroxysmal and is increased by the act of defecation.

The diagnosis is made by inspection. On separation of the cheeks of the buttocks, the sentinel pile of Brodie may be seen, if present, and often the lower portion of the fissure. Most often, the fissure is located in the posterior midline.

The treatment to secure a permanent cure is surgical. The writer prefers a low spinal anesthetic and the patient in the inverted (jack knife) position. With sharp dissection a wide excision is made to include the skin, the anal fissure and all of the scar tissue base, the anal crypt, and the sentinel pile. The subcutaneous component of the external anal sphincter is cut at the posterior midline.

Abscesses and Fistulae

An abscess of the anorectal region is a localized collection of pus in a cavity. Usually the abscess arises from an infected anal crypt. Should the abscess drain to a secondary opening, either spontaneously or surgically, a fistula is formed. An anal fistula may be defined as a pathologic tract having its primary opening in an anal crypt and its secondary opening at some adjacent tissue, viscus, or skin surface.

The symptoms and signs of an anorectal abscess are those of inflammation. It is severe pain, however, that forces the patient to seek medical care. The pain is

acute and throbbing and increases in intensity until the abscess is ruptured, either spontaneously or surgically. Should the fistula become blocked, an abscess may result and produce the throbbing pain and other clinical manifestations of inflammation.

The anorectal abscess is treated by incision and drainage. Usually, by the time the patient seeks treatment, the abscess is "ripe" for incision. The treatment should be done under general or spinal anesthetic.

The treatment of the fistula is surgical. The principal factors for successful treatment of anal fistula have been set forth by Buié² as follows:

"1. The primary opening must be found. 2. The fistulous tract or tracts must be traced. 3. Structures external to the primary opening and the fistulous tracts must be cut away so that the fistulous tunnels are converted into open ditches throughout their entire course. 4. Measures must be adopted during and following the operation to insure that the cavity will heal from within outward, without development of further tracts."

Hemorrhoids

Hemorrhoids are defined by Bacon³ as "varicose dilatations involving one or more radicles of the hemorrhoidal veins". Hemorrhoids may be classified according to whether they originate above the mucocutaneous junction (internal hemorrhoids) or below the mucocutaneous junction (external hemorrhoids). Often, they are mixed, possessing both internal and external components. External hemorrhoids are covered with skin, internal hemorrhoids with mucous membrane.

While everybody has hemorrhoidal veins, the symptoms of hemorrhoidal disease do not appear until the veins have become inflamed, thrombotic, ruptured, protruding, ulcerated, or necrotic. Not infrequently, there are other anorectal lesions in addition to the hemorrhoids.

The type of pain produced by hemorrhoids may vary from dull to sharp. Simple internal hemorrhoids may produce only a dull pain, or a sensation of fullness in the rectum. External thrombotic hemorrhoids produce continuous severe throbbing pains made worse by defecation. External thrombotic hemorrhoids should never be replaced or reduced.

The treatment of hemorrhoids is palliative and/or surgical. Palliation involves proper bowel hygiene and an adequate diet. Uncomplicated small to moderate internal hemorrhoids may be injected. Surgical treatment is indicated for hemorrhoids that produce intermittent or persistent pain and/or bleeding. This writer uses the "ligature-excision" technique; it is adequate and flexible for most hemorrhoids which require operation.

Pruritus ani

The consideration of pruritus ani as a painful lesion might be questioned. No one will dispute, however, the fact that the chronic itching produces irritability, aggravation, and much suffering.

Pruritus ani is a syndrome characterized by chronic anal and perianal itching of varying degrees. The treatment of this condition is difficult as attested by the continuously increasing list of varied preparations and procedures. Among the newer drugs, this writer has found histadyl and surfacaine cream (Lilly) and furaspor cream (Eaton) of value. In some cases of pruritus ani surgical treatment is necessary.

Miscellaneous

There are other lesions that produce pain at the anorectal region, such as anal chancroid and foreign bodies. They occur relatively uncommonly.

PAINLESS LESIONS

Polyp (adenoma)

This is a benign epithelial tumor. Polyps may be single or multiple, sessile or pedunculated.

As a rule the polyp is a painless lesion. The exception is the pedunculated polyp located near the sphincters. Most often, the polyp is discovered on routine proctoscopic examination, which should be a part of every physical examination. Whenever a polyp is discovered in the rectum, a careful search should be made by sigmoidoscopy and barium enema for other polyps or carcinoma higher up.

The polyp is a precancerous lesion. No polyp should ever be allowed to remain in the rectum after its presence is known. The treatment is surgical.

Carcinoma

Carcinoma of the rectum has been arbitrarily classified as a painless lesion. Early carcinoma, in the stage when operation can expect to be the most successful, is a painless lesion. Because early cancer is painless the physician should maintain a high index of suspicion if he expects to do his part to reduce the mortality from cancer. Rectal carcinoma is painful in its advanced stage as the result of ulcerations or invasion of contiguous strictures. Also, rectal carcinoma is painful when its location is near the anus and involves the anal tissues. Anal carcinoma, or epithelioma, is a painful lesion.

Mention should be made of the limitations of roentgenography in searching for lesions of the rectum. There are technical difficulties in visualizing clearly the barium enema in this region. This results in uncertainties in interpretation. Therefore, a negative report is no assurance that a growth does not exist in the rectum of the patient. It does not seem sound and logical to rely on roentgenograms for only indirect evidence when the sigmoidoscope provides direct vision of the lesion. A satisfactory proctoscopic examination should be made before subjecting the patient to the nuisance and expense of a barium enema.

The treatment of cancer of the rectum is surgical. The aim of the surgeon is to perform a curative operation for cancer. The cure of cancer depends on early diagnosis. Therefore, the hope of the surgeon to per-

form a really curative operation rests on finding the cancer in its early stage.

Welch and Giddings⁴ in an excellent report on carcinoma of the colon and rectum, based on cases at the Massachusetts General Hospital, concluded with: "The outstanding fact is that nearly two thirds of all patients with cancer of the colon and rectum are incurable when they reach the hospital. Deaths from this disease cannot be reduced by further improvement in operative technique, since mortality is now so low that no significant gain can be expected in this respect in the larger clinics. In smaller hospitals, it is probable that the mortality is still too high and operability too low. Further control of the disease will depend on routine proctosigmoidoscopy as in integral portion of the physical examination, to discover the disease before symptoms are manifest, and prompt treatment by well trained surgeons."

Lymphogranuloma venereum

Lymphogranuloma venereum is a virus disease usually transmitted by venereal contact. The rectum is frequently involved. The early lesion in the rectum is a painless inflammatory process. The rectal stricture is a later manifestation. Most strictures are painless. The lesion is painful when the inflammatory process approaches the anal structures, when perirectal abscesses develop, and when the stricture produce obstruction.

Lymphogranuloma venereum is best treated with aureomycin or chloromycetin. At times, surgical treatment is necessary.

Miscellaneous

There are other lesions of the anorectal region that are painless. Mention may be made of tuberculosis, granuloma inguinale, chancre and condyloma latum of syphilis, and condyloma acuminatum (venereal warts).

SUMMARY

A practical consideration of anorectal lesions based on the presence or absence of pain has been presented. Since the patient complains of pain, painful anorectal lesions are rarely missed. On the other hand, painless lesions, often of a serious nature, frequently go unnoticed by the patient. Because of the possibility of missing serious painless lesions the sigmoidoscope should be used more frequently as a diagnostic aid.

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The Management of Acute Injuries to the Neck*

COMMITTEE ON TRAUMA
AMERICAN COLLEGE OF SURGEONS

Injuries to the neck vary in extent and significance from the trivial, superficial and inconsequential to the most extensive, deep, disabling and life endangering. The size of the external wound and the extent of tissue damage are not always distinguishing features between the two extremes. Many neck wounds that appear to be slight in character are immediately fatal or become so soon after injury. However, if the patient can survive long enough to receive care adequate to the needs, even the severest wounds may be cared for with survival of the patient. Thus an injury to the neck is never slight enough to be neglected nor extensive enough to be regarded as hopeless.

First Aid

1. Apply a sterile dressing of adequate size, shape and volume to cover the wound, prevent flow of blood, and avoid further contamination.
2. Fix the dressing in place with adhesive tape, or with a bandage which is anchored about the head, jaw or opposite axilla.
3. If loss of blood has already resulted in shock, give one or two units of plasma or other blood substitute.
4. Direct the patient immediately to an emergency aid room or hospital for examination and treatment.
5. *Do not tamper with the wound, remove foreign bodies or disturb blood clots.*
6. *Do not apply a snug circular bandage around the neck.*

Immediate examination of patients with neck wounds will help to classify them into (I) those who may be given necessary care at a well equipped emergency room; and (II) those who require more adequate facilities and personnel for proper treatment.

The latter must be separated into patients who require

IIa *Urgent care* for respiratory obstruction or hemorrhage,

IIb *Delayed care* pending arrival at a hospital where adequate attention is available.

Answering the following questions will help to classify the patient.

1. Is respiratory obstruction present, impending or likely?
2. Is there a vascular injury with external or internal hemorrhage?
3. Is there an injury to the cervical cord or is such an injury likely?
4. Is there a foreign body lodged in the neck?

*Note: The foregoing is one of several articles on the subject of trauma distributed by the Committee on Trauma, American College of Surgeons, through its Regional Committees.

5. Is there an injury to the pharynx or esophagus?
6. Is there an injury to the head above or the chest below the neck wound?
7. Does the patient have other injuries requiring special care?

I Patients with wounds which do not involve the important structures outlined above are treated as follows:

1. Protect the open wound with a sterile dressing while cleansing a wide surrounding area with plain soap and water. Hairy parts are shaved.
2. Infiltrate the margins of the wound through the intact skin with a one per cent solution of procaine.
3. Cleanse the wound and excise devitalized tissues.
4. Close the wound with the least number of interrupted nonabsorbable sutures necessary for adequate approximation without tension.
5. Apply a sterile dressing and supporting bandage.
6. Tetanus antitoxin or tetanus toxoid and antibiotic medication should be given when circumstances and the nature of wound warrant this treatment.

Constricting bandages should not be applied to the neck of any patient who is unconscious, or may become so following medication, unless there is someone in attendance to guard against strangulation from hemorrhage, edema, or any other cause for tracheal obstruction or venous compression.

It is sometimes advisable to transport these patients in a prone position when the presence of tracheal or esophageal injuries renders possible fatal aspiration of secretions, vomitus, or blood.

II In the case of patients who require more adequate facilities, the wound should be covered with a sterile dressing of appropriate size, and the patient should then be sent to a hospital where the care necessary for such wounds is available. Even in the well equipped emergency room probing of neck wounds and removal of blood clots should not be done unless one is prepared to control hemorrhage and supply blood in a volume sufficient to prevent or overcome shock. However, the urgent case must be cared for promptly.

I. Injuries to Air Passages

Respiratory obstruction may result from (1) aspiration of blood or a foreign body; (2) direct trauma to the larynx or trachea; (3) edema due to injuries to adjacent structures in the neck or floor of the mouth; and (4) increased pressure in the neck due to hemorrhage from an artery, large or small.

Respiratory obstruction when impending, or likely to occur from the nature of the neck wound, warrants

immediate hospitalization lest an urgent condition be precipitated. Morphine should not be given to a patient with impending obstruction.

When strangulation is already present or developing, immediate tracheotomy is necessary. Done soon enough, even under the most unfavorable circumstances, it may be lifesaving. Inspiratory indrawing at the suprasternal notch, supraclavicular fossae and epigastrium, indicates the urgency of the condition.

The preparation of the skin for tracheotomy is done as in any elective procedure but the urgency of the situation may curtail some or all of the steps commonly taken.

1. The trachea is fixed between the thumb and index finger.
2. Skin incision is made over the trachea. A longitudinal incision in the midline of the neck is the most expedient.
3. Fascia is separated in the midline.
4. Incision made into two tracheal rings (at least two rings below cricoid cartilage).
5. Insert tube—metal, rubber or glass, whatever is available. Instruments—a forceps, bent hairpin, paper clip or other object—may have to be improvised on the spot.
6. Suction is accomplished with bulb syringe and catheter. Dependent position of head may aid in emptying the bronchial tree of blood or secretions and permit aeration of the lungs.
7. Patient is hospitalized for more definitive care of condition.

Elective tracheotomy done under better circumstances differs from the urgent type in the following particulars:

1. Adequate preparation of the skin.
2. Anesthesia (one per cent procaine infiltration along line of incision).
3. Skin incision. Similar to a thyroidectomy incision placed at a level below the cricoid but well above the suprasternal notch.
4. Fascia incised in the midline over the tracheal rings.
5. Insertion of a canula of proper size with obturator.
6. Suction apparatus, oxygen for inhalation.
7. Nursing care.

Injuries to the trachea or larynx due to blunt objects may result in edema even as late as forty-eight hours after injury. Tracheotomy may become necessary at any time. Lest strangulation develop and result in delay in establishing an airway, these patients must be observed by competent attendants. The gradual development of anoxia may be too subtle to be recognized until sudden changes occur and prove fatal.

Penetrating or perforating wounds of the respiratory passage are usually associated with emphysema of the

superficial tissues. These wounds should be exposed and cleansed but they need not be closed by suture. The skin should be loosely approximated lest infection develop and interfere with the healing process. Large tracheal wounds may be covered with adjacent muscle tissue or thyroid gland if available. It is best not to place a tracheotomy tube into wounds of the trachea close to the cricoid cartilage. When necessary, the tube should be inserted at the elective site in the trachea.

Tracheotomy tubes should be removed as soon as possible, when the airway is patent. This can be determined by plugging the opening in the tube or by substituting a tube of smaller caliber.

When possible, the advice and services of a laryngologist should be sought for the care necessary to prevent the sequelae of these injuries.

2. Injuries to Vessels

Bleeding from superficial vessels is controlled by ligation. When injury to a large vessel is suspected or actually present, manipulation of the wound should be avoided lest disturbance of a protective blood clot result in uncontrollable hemorrhage. Care of injuries to large vessels requires (1) blood for replacement; (2) intratracheal anesthesia; (3) oxygen; (4) adequate assistance to aid in exposure of the wound and control the blood flow in the carotid, or innominate or subclavian arteries, and one or two of these vessels may require control to help locate and ligate a bleeding vessel or vessels; (5) suture material and instruments of proper size and design; (6) adequate lighting; (7) nursing care.

Unless these facilities are available, and pending transportation to a hospital, the wound should be covered with a compression dressing held in place by adhesive tape which does not encircle the neck, or by manual compression.

Penetrating or perforating wounds of small size associated with severance or perforation of large vessels may be accompanied by little or no external bleeding. The neck becomes swollen because of venous compression and accumulation of blood in the fascial spaces. This is commonly associated with difficulty in breathing due in part to tracheal compression and in part to factors associated with increased pressure in the neck but not related to a decrease in size of the airway.

It is of some value to distinguish between strangulation due to a defect in the airway and strangulation due to internal tension in the neck. Decompression of the fascial spaces by incision into them will relieve the respiratory difficulty, but the bleeding point must now be controlled lest fatal hemorrhage ensue. Intratracheal anesthesia with a high oxygen content is extremely useful. Operating procedure is as follows:

1. Skin incision over the anterior border of the sternomastoid muscle on the side of the injured vessel.
2. Compression by stick sponge over site of injury.

3. Isolation of carotid artery below the wound with application of tape sling.
4. Isolation of carotid artery and jugular vein above the injured site with application of tape slings.
5. Exposure of the injured segment of vessel, and wound cleansed of clots, loose tissue, and tag.
6. Closure of artery wound either by a continuous nonabsorbable suture (0000 on needle) or ligation with a braided silk ligature close to adjacent branches with removal of the damaged segment. The smaller the caliber of the artery the finer the ligature necessary to occlude the lumen. Veins are ligated close to branches to avoid sacs of non-circulating blood. In injuries to the common carotid every effort should be made to apply lateral suture to avoid hemiplegia.
7. Skin is closed loosely. No drains are used in such wounds.
8. Firm bandage is applied and adequate nursing care instituted.
9. Whole blood in the amount required to replace the volume lost.
10. Antibiotics in full dosage. Tetanus antitoxin or toxoid as indicated.
11. Oxygen inhalations if any large vessel to the brain is occluded.

3. Injuries to Cervical Cord

Penetrating and perforating wounds in the neck may be caused by missiles which lodge adjacent to the cervical cord. The wound may appear trivial and the patient may walk into the emergency aid room but die suddenly following manipulation of the neck. Fractures and dislocations of the neck may be unassociated with cord injury until manipulation causes changes which result in paralysis or death. Thus, suspicion that such a sequel is possible warrants extreme care and study of the case with x-ray views before extensive manipulations are undertaken. The management of cord injuries is considered elsewhere.

4. Foreign Bodies

Patients with perforating wounds, lacerations and superficially imbedded foreign bodies obvious on inspection, do not warrant immediate x-ray studies. However, penetrating wounds with the possibility of a foreign body lodged in the neck warrant x-ray study to determine the probable course of the missile, its site of lodgement, and the likely damage resulting therefrom. Two views, antero-posterior and lateral, are taken. They should include the base of the skull and the clavicles. Depending upon the direction of the wound, studies of the skull or chest may be necessary to complete an evaluation of the extent of the injury. It is extremely important that the *left* and *right* sides be correctly marked on the films and that the examination of the neck be made with these markings clearly in view. Missiles which enter on one side of the neck may lodge on the opposite side and do more damage at the site of lodgement than on the side of

entrance. Thus, surgical care may be more urgent on the side opposite to the external wound. A misinterpretation of the film as far as the side of lodgement of the missile is concerned may result in a futile effort to improve the condition of the patient.

5. Injuries to Pharynx and Esophagus

These injuries may be noted on inspection, suspected from the course of a missile, or become obvious when complications develop. Exposure of the site of the wound with decompression of the fascial spaces or mediastinum, is all that is necessary in most instances. In small wounds healing occurs without suture, but repair of large rents is desirable in order to avoid persistent leakage of secretions. Feeding through a nasal catheter is desirable for a period of a few days to one week, depending on the size of the opening. Extensive wounds of the pharynx or esophagus may heal better without an indwelling catheter. The establishment of a gastrostomy or jejunostomy may better accomplish maintenance of nutrition without interfering with the healing process in the neck. Following necessary care at the site of injury, the skin is closed loosely, and a drain put into the fascial space.

6. Wounds Adjacent to Jaws, Chest, Axilla, Head

The bony barrier between the neck and chest is the first rib on each side attached to the sternum. The bony barrier between the neck and axilla is the clavicle on each side. These barriers between adjacent zones of soft tissue interfere with the freedom of manipulation which is frequently necessary to cope with wounds of the neck extending to the chest or axilla.

The floor of the mouth and mandible are also frequently injured in wounds involving the neck. Thus these zones adjacent to the neck must be studied and, when necessary, exposed in order to complete the care of injuries to important structures (blood vessels, food and air passages). The control of blood flow in the carotid, innominate and subclavian arteries must not be undertaken lightly in an emergency room. The possibilities of the complications noted above emphasize rather the need for the careful examination and triage of patients with neck wounds.

7. Concomitant Injuries

Failure to examine the rest of the body of the patient who has a severe neck injury may be cause for an avoidable disability or a fatal issue, even when proper care for the neck wound has been carried out. Thus the casual survey of the initial examination must be followed by more thorough study by all personnel who are charged with the responsibility for the care of the patient. An unreduced dislocation of a thumb may be insignificant when compared to a life endangering wound in the neck. However, while he may recover from the neck injury, the patient may be left with a disabled hand.

The Journal of the South Carolina Medical Association

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Florence, S. C.

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PROPOSED CHANGES IN STATE BOARD OF HEALTH

The opinion has gradually developed among many, both within and without the medical profession, that changes should be made in the executive body of our State Board of Health so that the public should have more representation—the public which pays the bills and receives the services. Faced with this situation our Council and House of Delegates took positive action, and rightly so since our Association was created in part to serve as an adviser to the public in affairs medical.

First our Council made a careful appraisal of the situation and this was supplemented by a study, made at the request of Council by Dr. Harry Mustard of New York—a native South Carolinian and a recognized authority in the field of public health administration. Council then made its report with recommendations to a called meeting of the House of Delegates in December. The House of Delegates, after full discussion, adopted the report in principle, changed certain of its recommendations, and brought forth a definite plan of reorganization which is to be presented to the General Assembly for consideration and action. (This proposed plan will be found in the Ten Point Program section of this Journal.)

Regardless of whether each member of the Association will agree with all of the details of the proposed plan, we feel that each member has a right to be proud of the way in which our Association has tackled the problem. No longer may it be said that the South Carolina Medical Association is opposed to any change, that it is so zealous of the rights of its physician-members that it refuses to appreciate the rights of others. Of its own accord and due to no pressure from without, the Association has proposed a plan which will give the public more voice and physicians less voice in the running of the State Board of Health. And this was done because it was believed that through such a plan the people of South Carolina would be served better. It is of such a spirit that true leadership is made.

A NEW HOSPITAL ACCREDITING AGENCY

Over the years the American College of Surgeons has done a splendid job in its hospital accreditation program. Thanks to the efforts which have been expended, the hospitals of this country are in excellent condition.

For some time, however, it has been realized that the task has become too complex and too costly for one organization to sponsor alone. During the past few months representatives from various organizations have been in conference with the result that a new agency has been established whose duty it will be to continue and amplify the program now being carried on by the College of Surgeons.

This new agency is to be known as the Commission for the Accreditation of Hospitals, and is composed of twenty one members—six from the American Medical Association, seven from the American Hospital Association, three from the American College of Surgeons, three from the American College of Physicians and two from the Canadian Medical Association. The first meeting of the Commission was held in Chicago recently for organizational purposes. A set of By-laws was adopted and Dr. Gunner Gunderson of Wisconsin (one of the A.M.A. representatives) was chosen as chairman.

The first task of the Commission will be to select an Executive Director and the choice is being made with extreme care since this man will be the key figure in further development. The next job will be that of reviewing and revising the present standards by which hospitals will be judged and accredited.

The American Medical Association will continue its work in approving hospitals for internships and residencies—and this is only right since it is strictly a medical affair. But it is hoped that the two programs, that of the Commission and that of the A.M.A., can be operated (through exchange of information and specific data) so that they will be of mutual benefit.

Until the Commission is ready to take over its work—and this should be some time later this year—the College of Surgeons will continue its present program of accreditation.

AUTOMOBILE EMBLEMS

There are a few "South Carolina Medical Association" automobile emblems left from the last order. These sell at \$3.25 per emblem and can be secured by writing Mr. M. L. Meadors, 120 W. Cheves St., Florence. Only members of the Association may buy them, and those ordering are asked to send check with the order.

RELATION OF PHYSICIANS AND HOSPITALS

At the recent meeting of the House of Delegates of the American Medical Association in Los Angeles a significant resolution was adopted with regard to the relationship of physicians and hospitals. It was presented by the Board of Trustees and was the result of many months of study and consideration. It is to be known as "Guides for Conduct of Physicians in Relationship with Institutions," and should be of interest and concern to all physicians who have any dealings with hospitals. It reads as follows:

"So far as it can be determined on the basis of study made by the Bureau of Legal Medicine and Legislation of the American Medical Association, as a matter of law the corporate practice of medicine is illegal in most states. In almost all instances the classic example given by the courts of the type of corporate practice of a profession that is illegal is the instance in which a corporation hires a professional man and then sells his services to the public on a fee basis for the profit of the corporation. Such exceptions as there are refer to statutory legislation in several states permitting certain modifications of this general law. It must also be remembered that fee splitting with a corporation is just as unethical as fee splitting with another physician.

"In addition to being guided by the laws of the various states, physicians in their relationships with hospitals must be guided by the Principles of Medical Ethics of the American Medical Association. Those sections of the Principles which have a distinct bearing on these relationships are as follows:

Chapter I, Sec. 3. "Groups and Clinics—The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual. As a group or clinic is composed of individual physicians, each of whom, whether employer, employee or partner, is subject to the principles of ethics herein elaborated, the uniting into a business or professional organization does not relieve them either individually or as a group from the obligation they assume when entering the profession."

Chapter III, Article VI, Sec. 2. "Conditions of Medical Practice—A physician should not dispose of his service under conditions that make it impossible to render adequate service to his patients, except under circumstances in which the patients concerned might be deprived of immediately necessary care."

Chapter III, Article VI, Sec. 3. "Contract Practice—Contract practice as applied to medicine means the

practice of medicine under an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision or individual, whereby partial or full medical services are provided for a group or class of individuals on the basis of a fee schedule, or for a salary or for a fixed rate per capita.

"Contract practice *per se* is not unethical. Contract practice is unethical if it permits of features or conditions that are declared unethical in these Principles of Medical Ethics or if the contract or any of its provisions causes deterioration of the quality of the medical services rendered."

Chapter III, Article VI, Sec. 6. "Purveyal of Medical Service—A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people."

In conclusion, the Principles of Medical Ethics states: "These principles of medical ethics have been and are set down primarily for the good of the public and should be observed in such a manner as shall merit and receive the endorsement of the community . . ."

On page 31 of the Constitution and By-Laws as printed in the Handbook under Duties of the Judicial Council, is found the following:

"The Council shall have jurisdiction on all questions of medical ethics and the interpretation of the laws of the Association.

"The Council at its discretion may investigate general professional conditions and all matters pertaining to the relations of physicians to one another and to the public, and may make such recommendations to the House of Delegates or the constituent associations as it deems necessary.

"The Council shall have authority to request the President to appoint investigating juries to which it may refer complaints or evidence of unethical conduct which in its judgment are of greater than local concern. Such investigating juries, if probable cause for action be shown, shall submit formal charges to the President, who shall appoint a prosecutor to prosecute such charges against the accused before the Judicial Council in the name and on behalf of the American Medical Association. The Council may acquit, admonish, suspend or expel the accused."

"The primary obligation of both physicians and hospitals is to serve the best interest of the patients. The decision as to the ethical or unethical nature of practice must be based on the ultimate effect for good or ill on the public as a whole. All of the various questions involved in the relationship between physicians and hospitals, both legal and ethical, particularly questions dependent on local conditions, must be considered in the first instance at the local level because of the various differences which of necessity exist in the many sections of the country.

"One of the factors that have aggravated physician-hospital relationship is the inclusion of medical services in the contracts of voluntary hospital service plans. The medical profession is fostering voluntary health insurance, and we believe that nothing should be done to disturb this very important and essential program.

However, the American Medical Association has reaffirmed many times through its then Bureau of Medical Economics, its Judicial Council, and the House of Delegates the principle that hospital service plans should exclude all medical services, and the contract provisions of such plans should be limited exclusively to hospital services. At the same time, so that there would be no misunderstanding as to which services should or should not be included, the House of Delegates has stated that "... if hospital service is limited to include only hospital room accommodations, such as bed, board, operating room, medicine, surgical dressings and general nursing care, the distinction between hospital service and medical service will be clear." (Proceedings of the San Francisco Session of the House of Delegates, 1938, p. 31) Past actions of the House of Delegates give every reason to reiterate that radiology, anesthesiology, pathology and psychiatry constitute the practice of medicine.

"In order to initiate a method for remedying this situation, it is recommended that Blue Shield and Blue Cross be requested to cooperate to the extent of writing all new contracts in such a manner that Blue Shield will cover insurable medical services and Blue Cross will cover insurable hospital services. It is hoped that the professional and hospital authorities and the voluntary prepayment plans will cooperate in furthering these recommendations.

"Since the physician and hospital are interdependent, it is incumbent on both to be interested in all phases of their scientific and financial relationships. This means that the professional staff of the hospital has very definite responsibilities toward not only other members of the professional staff, whether active or courtesy, but also toward hospital management. The recommendations of the staff concerning medical matters are usually accepted by the management of the hospital through its board of managers or trustees. It must also be remembered that to be approved for residencies in specialties by the American Medical Association and the American College of Surgeons, certain requirements are mandatory to the institution, among them adequate pathologic and radiologic coverage. As a rule, the staff of a hospital elects an executive committee or works under an appointed executive committee to advise the lay officers of the institution on purely professional matters, and recommends who may or may not use the institution for professional work. Unfortunately, in many instances, the financial problems of the lay hospital management have been no affair of the staff or of its professional executive committee. This is wrong and probably the cause of most of the differences of opinion between physicians and hospital management. The financial problems of an institution in which a physician does his professional work are definitely of importance to him and to the professional staff, and the proper consideration must be given to these problems if the hospital is to work efficiently and remain the workshop of the physician, and without proper

facilities the services rendered to the public are in jeopardy and these public services are the all-important function of both hospital and staff.

"Every professional man on the appointed staff should have a voice in the professional management of the institution. The pathologist, roentgenologist, anesthesiologist and psychiatrist, as well as the other professional staff members, should have equal standing as active members of the staff with all the rights and privileges pertaining to other members of the staff of equal standing. The chiefs of these departments should be nominated and appointed in the same manner as are the chiefs of other major departments in the same hospital.

"The revised Principles of Medical Ethics has been written with all of these various factors in mind and is broad enough to cover all possible ethical physician-hospital relationships. The Constitution and By-Laws of the American Medical Association distinctly covers methods of procedure for all persons who have a complaint so that they may approach the Judicial Council. The functions of that Council are specifically delineated.

In the event of a controversy between physician and physician or physician and hospital management, on these problems, it is recommended that, since local conditions must be taken into consideration, these problems be resolved insofar as possible at the local level.

There can be no exploitation of the doctor or of the hospital if everyone concerned in management and on the professional staff will work together to supply the greatest possible good quality medical and hospital services to the public. In any given controversy, every effort should first be made to settle the matter at the staff-management level. In case of failure to settle the controversy at this level, assistance of the county medical society should be requested. If, then, it cannot be resolved it should be submitted to a committee of the state medical association for advice and recommendation. If problems cannot be solved at the staff-management level, through the county medical society, or through the state medical association, the Constitution and By-Laws of the American Medical Association provides that "... the (Judicial) Council, at its discretion, may investigate general professional conditions and all matters pertaining to the relations of physicians to one another and to the public, and may make such recommendations to the House of Delegates or the constituent associations as it deems necessary."

"To implement the settlement of such controversies, it is recommended that each component medical society and each constituent state and territorial medical association appoint a Committee on Hospital and Professional Relations. This committee should be available to receive complaints from any physician, hospital, medical organization, or any other interested person or group with reference to professional or economic relations existing between doctors of medicine and hospitals. On receipt of such complaint by such a committee the matter should be investigated and acted on in such manner as will best effect adjustment of the complaint.

"Another approach that should not be neglected in

activating this report is that of the local and state hospital associations. Most of the states and many communities have hospital associations providing direct representation for the hospitals within their areas. It seems reasonable to assume that state medical associations and component county medical societies could well effect liaison with these organizations in the settlement of problems involving physician relationships.

"In summary, the following general principles are suggested to individual physicians, county medical societies, and state medical associations as a basis for adjusting controversies, these principles, however, to be qualified to the extent required by the applicability of one or more of the factors heretofore mentioned:

1. A physician should not dispose of his professional attainments or services to any hospital, corporation or lay body by whatever name called or however organized under terms or conditions which permit the sale of the services of that physician by such agency for a fee.

2. Where a hospital is not selling the services of a physician, the financial arrangement if any between the hospital and the physician properly may be placed on any mutually satisfactory basis. This refers to the remuneration of a physician for teaching or research or charitable services or the like. Corporations or other lay bodies properly may provide such services and employ or otherwise engage doctors for those purposes.

3. The practice of anesthesiology, pathology, physical medicine and radiology are an integral part of the practice of medicine in the same category as the practice of surgery, internal medicine or any other designated field of medicine."

A. M. A. MEETING IN LOS ANGELES

(A travelogue)

Sunday, December 2—

From South Carolina to California in 13 hours flying time is no longer news for the front page, it has become an every day occurrence. Leaving Florence at 10 a. m. I flew to Washington where I boarded a United Air Lines mainliner which flew non-stop to Denver. An hour's wait in that city and then another non-stop to Los Angeles, arriving at 10:30 p. m. (Pacific time). It was dark when we flew over the Rockies so we couldn't see the mountains.

Our first sight of Los Angeles came from the plane as we approached the city. Twinkling lights of all colors spread over the ground for miles and miles up and down the coast and gave us a slight idea of the immense territory which the city covers. Our first closeup of the city was experienced on our fifteen mile drive from the airport to the hotel. We drove through Glendale and one could have easily mistaken the surroundings for the residential areas of South Carolina towns. The homes were almost all bungalows, frame or stucco, with small yards. Palm trees lined many of the streets. Nowhere did we see the closely-built tenement houses which line the streets of any other large cities. Finally as we approached the hotel area we began to note tall buildings and the appearance of a city. It was almost midnight when we reached the Biltmore Hotel (midnight California time that is, 3 a. m. Palmetto state time) and I was ready for bed.

Monday, December 3—

Most of the day was spent in attendance upon the fourth annual Medical Public Relations Conference, sponsored by the A.M.A. Representatives of most of the states were present, including many public relations directors and executive secretaries. The morning session was centered around the theme—Public Relations Problem Number One: The High Cost of Sickness. The addresses were interesting, thought-provoking and practical. Jack Meadors will publish extracts from these when they are available, in his department in this Journal. I listed some of the outstanding ideas expressed and pass them on for consideration:

The cardinal sin in medical practice is to fail to give the patient and his disease every consideration as regards the diagnosis, the treatment, and the fee.

The maximum charge for any operation should not exceed one month's income of the patient, after taxes are paid.

One of the best ways to reduce hospital costs is to cut out unnecessary laboratory work and expensive drugs that are not directly indicated.

Tell the patient about the "extra hospital costs" before he goes to the hospital—it will help immeasurably.

When you prescribe an expensive drug in the hospital tell your patient about it before he gets the bill.

If tissue is examined in the pathological department, tell your patient so and explain the reason for such.

It isn't as much a question of what the fee is as it is a problem of having the patient understand what the fee is for and being satisfied.

Remember that a patient's time is valuable too. One of the greatest gripes against doctors is, "He makes me wait."

What happens in your reception room will reflect itself a great deal in your personal office public relations.

If you can't see your patient on time, see to it that your secretary or nurse explains the delay.

Don't put up with a secretary or nurse who antagonizes your patients. Change her or fire her. If she can't smile, make her practice in front of a mirror at home.

A great deal of public relations dynamite is packed in the way a doctor tries to collect past-due accounts. The best type of collection agency is one which is controlled by physicians themselves.

The speaker at the luncheon was Dr. Lewis Alisen, surgeon of Los Angeles and president-elect of the California Medical Association. He spoke on the subject, "The Physician's Responsibility as a Leader," and never have I heard a practicing physician who was so well versed in economic and political history and who was so able to give such a thorough philosophic background for his well organized speech. Speaking, and not reading from a manuscript, he held his audience in his hand for thirty minutes and the applause which he received was spontaneous and prolonged. I will try to get his address for publication in this Journal.

The afternoon session was devoted to a discussion of the cooperation of medical organizations with other groups, and to the future public relations plans of the A.M.A. and of state associations. Leo Brown, newly appointed director of public relations of the A.M.A., made a good impression and I predict that he will be doing an excellent job in the days ahead.

During the evening the officers of the Association and members of the House of Delegates were guests of the Los Angeles County Medical Society at a banquet at the Cocommt Grove. It was a sumptuous affair with Hawaiian food served against the background of Hawaiian music. Jean Hersholt (Dr. Christian of movie and radio fame) was a guest and gave a brief talk, telling of some of his experiences. The main entertainment was furnished by a Hawaiian musical and dancing troupe, and by Edgar Bergen who was accompanied by Charlie McCarthy and Mortimer Snerd.

On the way back to the hotel my fellow riders and the taxi-drive gave me more information about this unusual city. Los Angeles is really an entire county with many communities (Englewood, Hollywood, Beverly Hills, etc.). Most of these communities are included in the city of Los Angeles. The city is spread over a vast area with one street running for 44 miles with only an occasional curve and never a right angle turn. The population is around 3,000,000 and there are over 4,000 doctors (over three times as many as we have in our state association). What a city!

Tuesday, December 4—

The House of Delegates convened at 9:30. The first action was to elect Dr. Yoder of Indiana the general practitioner of the year. Following this we heard reports from the officers and various councils. John Cline, President of the A.M.A. (who visited S. C. recently and spoke in Greenville, Columbia, and Florence) gave a stimulating address. He outlined the broad tasks which face physicians today; the continued fight which must be waged against socialism, the need for cleaning our own houses through grievance committees, the necessity for explaining to the public why the cost of medical care is of necessity so high, the desirability of state associations and individuals contributing to the Medical Foundation Fund, the need for more cooperation with non-medical groups and individuals, and the opportunity for encouraging and expanding the work now being done by national and state women's auxiliaries.

Mr. Donald Wilson, national commander of the American Legion, was introduced and spoke briefly. He stated that the doctors are the most respected group in this country and accordingly have a great responsibility—not only in medical affairs but in social and economic as well. "You must never be placed in a defensive position," he stated, "you must lead." He drew prolonged applause when he stated, "Our Legion is irrevocably opposed to socialized medicine."

Dwight Murray, Chairman of the Board of Trustees, announced that the A.M.A. had appropriated another \$500,000 to the Medical Education Fund. He also announced the creation of the new Joint Commission for the Accreditation of Hospitals. This group is composed of eighteen men—six from the A.M.A., six from the American Hospital Association, three from the Amer. College of Surgeons, and three from the Amer. College of Physicians—and will take over the task of accrediting hospitals which is now being done by the American College of Surgeons. (The Commission is scheduled to hold its first meeting in Chicago, Dec. 15, 16).

During the afternoon resolutions were presented from state associations and from individual delegates and these were referred to the various committees for hearings and recommendations.

At 3:30 the Legislative Committee went into session, and except for a short pause for supper we kept working until nine o'clock. This committee is composed of nine men from different sections of the country and its function is to study all legislation proposed in Congress and to make recommendations

to the Board of Trustees as to what position the A.M.A. should take with regard to them. There is still a mass of legislation pending in Congress which deals directly or indirectly with doctors or medicine and we went over these bills, one by one. It is interesting work but leaves one rather exhausted at the end of such a session.

Wednesday, December 5—

The morning was set aside for hearings before the reference committees. Each committee takes up the resolutions which have been referred to it and any member of the Association may listen to the discussions or present his views. It is not only a highly democratic procedure (one of the best arguments which I heard was given by a physician who is not a member of the House of Delegates) but also both interesting and informative. I was particularly interested in a resolution which dealt with the question of allowing negro physicians to become members of the A.M.A. Louis Orr of Florida and I both spoke to the question as did Dr. Peter Murray of New York, the only negro member of the House of Delegates. We were all impressed by his tolerance, and agreed with him completely when he urged that we proceed slowly and attempt to work things out on the local state and county levels.

During the afternoon I went to the Shrine Auditorium and took in the scientific and commercial exhibits.

The evening was devoted to the historic meeting at which Senators Byrd and Taft spoke to an overflow crowd of 6,500. The speeches were broadcast and no doubt were heard by many in South Carolina. They were also televised for the California area. The talks were hard-hitting, outspoken attacks upon the present administration's activities in the field of socialism and finance. Both men received ovations but Senator Byrd probably pleased the audience more because of his informality and lack of reserve.

After the meeting a buffet supper was served at the Biltmore Hotel where the members of the House of Delegates were given the opportunity of meeting the Senators. When I was introduced to Senator Byrd, he quipped, "Just do what your Jimmy Byrnes tells you, and you will be all right."

Thursday, December 6—

The final session was held this morning with adjournment at 1:30. Thanks to the discussions which had been held before the reference committees most of the steam had been blown and there was not too much debate, although two or three of the reports produced lively discussion.

One resolution dealt with the relationship between physicians and hospitals. This subject has been under much discussion over a period of years and it is hoped that the statement adopted (printed elsewhere in this Journal) will clarify the atmosphere.

The trip back was made with a 24 hours stopover in Salt Lake City to visit my brother who is Professor of Surgery at the Utah Medical School. Four inches of snow in that city with a temperature of 8° being recorded during the night gave me a real taste of winter.

The scene which met our eye as we flew from Salt Lake City to Denver during the late afternoon is one which I will not soon forget. Great rugged mountain peaks, covered with snow, glistening in the bright sunshine against a background of black shadows reaching into the valleys below.

It is hard to give a general impression of a meeting of this type, and yet I had the feeling—and I think our other delegate, William Weston, Jr., will agree with me that this House of Delegates was made up of men who were aware of the progress which had been made during recent years and of the work which

still remained to be done. The threat of socialized medicine had been halted temporarily but the threat is still present. The problem of securing the best possible medical care for the American people at the least possible cost is still with us and will continue to challenge the best in us for years to come.

WHAT IS A REPORTABLE CASE OF TUBERCULOSIS?*

The reporting of cases is indispensable to the control of tuberculosis. A health department cannot discharge its responsibilities for the supervision of cases and the examination of contacts if all cases identified in its jurisdiction are not brought promptly to its attention.

Furthermore, reliable information about the extent of the problem is necessary for intelligent planning of control programs. Although reporting of tuberculosis has been in effect in South Carolina for several years there has been so little agreement on definitions of reportability or uniformity in reporting practices that available tuberculosis morbidity data have represented only makeshift estimates. Mortality rates can no longer be used as a measure of control needs since in recent years the rapid decline in the death rate has not been accompanied by a commensurate decline in morbidity. As case-finding efforts are carried on with increasing vigor and more cases are discovered in the minimal stage, and as new drugs and other methods of therapy prolong the lives of tuberculosis patients, it is apparent that mortality rates are no longer an accurate current guide to the tuberculosis problem. For example, in South Carolina there were only 434 deaths attributed to tuberculosis in 1950, while 5,742 known, living cases of tuberculosis were on file in the office of the Section of Tuberculosis Control.

To be really useful tuberculosis case reporting should conform to commonly accepted standards. Data are of little use if some reflect all cases including suspects, while others show only active cases with positive bacterial findings.

A. For the sake of uniformity in case reporting by the Physicians of South Carolina it is suggested that the FOLLOWING CASES BE REPORTED TO THE STATE BOARD OF HEALTH:

1. Cases with tubercle bacilli demonstrated.
2. Cases with other significant evidence, even though bacteriological proof has not yet been demonstrated, such as:
 - a. Chest X-ray shadows characteristic of active tuberculosis (soft infiltrate, cavity, etc.);
 - b. Unexplained pleurisy with effusion;
 - c. Clinically active extra-pulmonary tuberculosis (meningeal, bone, kidney, etc.).

B. The FOLLOWING PREVIOUSLY UNREPORTED TUBERCULOSIS CASES MAY BE

(*Information received from Dr. F. L. Geiger, Division of Disease Control, S. C. State Board of Health).

REPORTED IF THE PHYSICIAN SO DESIRES:

1. Cases of pulmonary fibrosis and nodulation more than minimal in extent presumably of tuberculous origin.
2. Cases with a record of active disease or previous treatment within the past 5 years.
3. Cases with X-ray evidence of collapse therapy or resection for tuberculosis.
4. Active primary pulmonary tuberculosis cases.

MEDICAL AND SURGICAL SYMPOSIUM

The 9th annual Watts Hospital Medical and Surgical Symposium will be held at the Carolina Theatre, Durham, N. C., on Wednesday and Thursday, Feb. 13 and 14, 1952. An outstanding program will be presented which will include special papers, a clinical-pathological conference and a panel discussion on endocrinology.

Among the men who will address the gathering are: Drs. Shields Warren of Harvard Medical School, Albert Faulconer, Jr. of the Mayo Clinic, Frank E. Adair of Cornell Medical School, Edwin C. Hamblen of Duke, Edward C. Reifstein of Oklahoma Medical Research Institute, Perry McCullough of the Cleveland Clinic, Nathan A. Womack of Univ. of N. C. Medical School, George Van S. Smith of Harvard Medical School, Charles H. Burnett of Univ. N. C. Medical School, and Hugh H. Hare of the Lahey Clinic.

DEATHS

EDGAR O. HORGER, JR.

Dr. E. O. Horger, Jr., 42, Greenville physician, was found dead in a hotel room in Jacksonville, Florida, November 26. He had suffered from a heart disease for some time prior to his death.

A native of Eutawville, Dr. Horger had practiced general medicine in Greenville since 1937 except for the time he served in the medical corps during World War II. He received his education at Wofford College and the Medical College of the State of South Carolina (Class of 1937).

Dr. Horger is survived by his widow, two daughters and two sons, all of Greenville.

NEWS ITEMS

Dr. E. G. Cannon of Pickens, was recently awarded the distinguished honor of being the "Citizen of the Year" in Pickens. The plaque was presented by the American Legion Post.

Dr. Robert Gregg, who returned from Japan in September, is now associated with Dr. J. D. Whitehead in Lake City.

Dr. Thad Bethea has opened offices in Latta for the practice of general medicine.

THE TEN POINT PROGRAM

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

RESOLUTION OF HOUSE OF DELEGATES FOR SUBMISSION TO THE GENERAL ASSEMBLY

1. Whereas, there have occurred many changes in the State Government and in the State's population and in the make-up of the South Carolina Medical Association and in the scope of the public health activities of the State since 1878, when "an act to recharter the South Carolina Medical Association and establish a State Board of Health and to define its duties" (Statutes at Large: South Carolina, 1878 No. 16, and included in the 1942 Code of Laws, Section 4997) was passed; and

2. Whereas, the act provided that the "officers and their associates," constituting the South Carolina Medical Association should be in their corporate capacity, together with the Attorney and Comptroller Generals, the Board of Health of South Carolina, to be known as the State Board of Health, and provided further that an Executive Committee of seven members should be selected by the State Board of Health and should be recommended to the Governor who should appoint them to the said Executive Committee for a term of seven years; and

3. Whereas the conditions of the present make desirable the participation of the public at large in public health matters by proper representation in the State Board of Health; now therefore Be It Resolved, by the House of Delegates of the South Carolina Medical Association, in its corporate capacity, that it petition the General Assembly of South Carolina that the following recommendations shall be enacted into law:

Recommendation 1. That the powers and duties now vested in the State Board of Health and in the Executive Committee of the State Board of Health be transferred to and vested in a State Board of Health of nine members to be appointed by the Governor as hereinafter set forth.

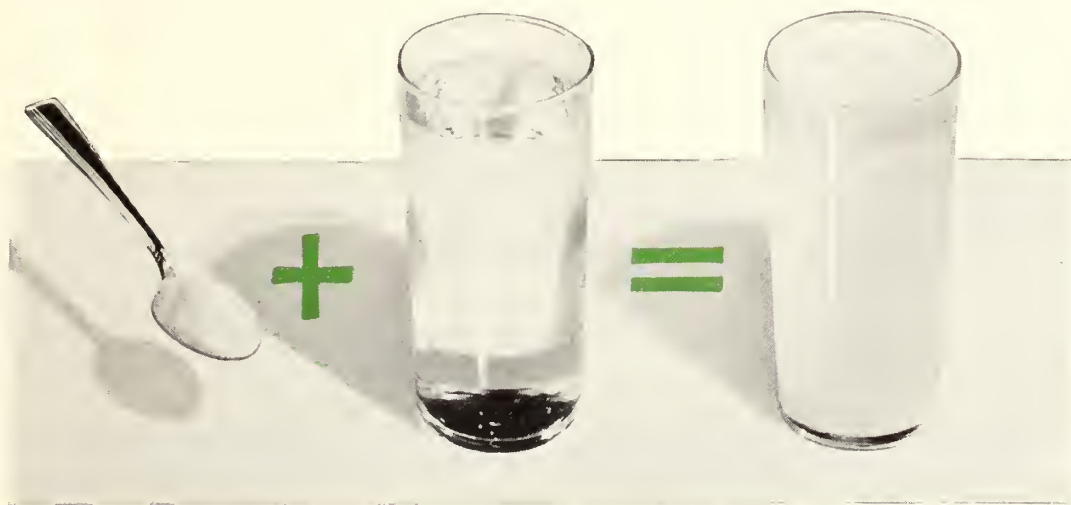
Recommendation 2. That the Governor shall appoint a State Board of Health consisting of nine members, including three physician-members; one member who shall be nominated to the Governor by the South Carolina Dental Association; one member who shall be nominated to the Governor by the State Nurses Association; one member who shall be nominated to the Governor by the South Carolina Pharmaceutical Association; and three other citizens of the State, none of whom shall be members of the medical, nursing, dental or pharmacy professions; that members of the Board shall be appointed in the categories set forth above as

provided respectively in Recommendations 3 and 4; that one physician and one non-professional member be appointed for a term of 2 years, one physician and one non-professional member be appointed for a term of 3 years, one physician and one non-professional member be appointed for a term of 4 years; all such appointments to date from the first Friday in July 1952; that appointments subsequent to that date, and the appointments from the dental, nursing and pharmacy associations, except for the filling of unexpired terms, shall be for a period of four years, and until a successor is appointed and qualified; that, except members who have not served for as long as twenty-four months, no member may be appointed immediately to succeed himself or herself but may be again appointed to the Board after one year's absence from appointment; that when a vacancy occurs, other than through expiration of term of appointment, the person appointed shall be qualified within the category in which the vacancy occurs and his or her term of office shall be the unexpired term of office of the person whom he or she succeeded; and if this unexpired term shall be 24 months or more, the member who fills it shall be considered as having served the equivalent of a full term insofar as concerns eligibility for a future appointment. Members of the State Board of Health shall be removable by and at the pleasure of the Governor for neglect of duty and other causes after a hearing of the Board, when at least five members of the Board certify to the Governor in writing that such a hearing has been held, and that they believe the charge or charges which they shall set forth, have been sustained and are sufficient cause for removal; provided: that no member shall be removed from the State Board of Health unless thirty days before the hearing of charges, he or she shall be advised, in writing, of the specific charge or charges and of the time and place of such a hearing.

Recommendation 3. That Section 4997 of the Code of 1942, and such other Sections as may be concerned, be so amended as to provide that the South Carolina Medical Association, at its first meeting after January 1, 1952, shall nominate 6 members to be recommended to the Governor on or before the next ensuing first Friday in June and the Governor shall appoint 3 of them, with others as set forth in Recommendations 2 and 4 hereof, to constitute a State Board of Health; and that the 3 members of the South Carolina Medical Association elected and recommended to the Governor by that Association, and not immediately appointed by him to the Board, shall be alternates, one of whom, or all, if necessary, shall be appointed by the Governor to fill any vacancies that may occur in the physician membership in the period between then and the first

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SEARLE RESEARCH IN THE SERVICE OF MEDICINE

Friday in July 1953; and that at each annual meeting subsequent to the first one after the first of January 1952, the South Carolina Medical Association and their successors, in their corporate capacity shall nominate two members for each vacancy to be recommended to the Governor, on or before the next ensuing first Friday in June of each succeeding year, and the Governor shall appoint one of them to each vacancy to serve as a member of the State Board of Health for a period of four years; and that the member of the South Carolina Medical Association, elected and recommended to the Governor by that Association and not immediately appointed by him to the State Board of Health, shall be an alternate and if necessary, shall be appointed by the Governor to fill any vacancy that may occur in the physician membership of the Board in the year for which he was recommended for appointment on the Board; and that the nomination and appointment of the representatives from the South Carolina Dental Association, South Carolina Pharmaceutical Association and the South Carolina Nurses Association, shall be made by procedure within the respective Associations corresponding to the procedure herein set forth for the appointment of physician-members.

Recommendation 4. That within thirty days after the Legislature adjourns, the Governor shall appoint three citizens of the State, who shall not be physicians and who, with others as set forth in Recommendations 2 and 3, shall constitute a State Board of Health, and when vacancies occur, the Governor shall appoint one citizen of the State, who shall not be a member of the Health Professions herein named; and that when vacancies occur in this category of the membership of the State Board of Health, other than through expiration of term of appointment, the Governor shall, within his discretion, and in not less than thirty days, appoint a citizen of the State, who shall not be a member of the Health Professions herein named, to fill the vacancy.

Recommendation 5. That if any, or all, of the professional associations herein designated as the nominating bodies for the appointment of the professional members of the State Board of Health fail or decline to make recommendations to the Governor, as herein before set forth, then the Governor shall, within his discretion, appoint professional members of the Board, as may be necessary and in the same proportion in the several categories herein before designated.

Recommendation 6. That the State Board of Health, as provided for above, shall meet on or before the first Friday in July 1952, shall proceed to organize and shall elect a chairman and a vice-chairman, and that it be empowered to adopt by-laws, and the Board shall be empowered to appoint and employ a State Health Officer, who shall serve in that capacity at the pleasure of the Board, and who shall also serve as Secretary of the Board. Further as vacancies occur, either by ex-

piration of term of appointment, by resignation, by removal from office for cause, in a manner similar to that provided for removal of members of the Board in Recommendation 2, or by death, they shall be filled by the Board in the same manner as their predecessors were elected or appointed.

It is the intent of this Resolution to recommend that the State Board of Health be organized as provided in this Recommendation, within thirty days after the date of adjournment of the General Assembly in 1952, if it is possible to do so, consistent with the method of nomination and appointment of its members as elsewhere provided herein.

The Board shall meet once in each month, and at other times when called by the Chairman at the request of four members of the Board. It shall fully and completely record its actions and shall carefully preserve its records. The State Health Officer shall assist the Board in the recording and preserving of records of its actions and shall assist the Board in the conduct of its business. Members of the Board shall be entitled to compensation and expenses as now provided. The Board shall render an annual report to the Governor and to the General Assembly.

Recommendation 7. That there be created the Department of Health of South Carolina, which shall be under the direction of the State Board of Health and administered by the State Health Officer.

HOSPITAL FACILITIES INCREASE IN SOUTH CAROLINA

The Division of Hospital Facilities, F.S.A., has reported that as of November 30, 1951, forty-seven projects at a total cost of \$8,156,708 and supplying 831 additional beds, have been completed and are in operation in South Carolina. The amount includes federal contribution of \$2,889,582.

According to the report, there are under construction as of the same date, fifty-eight projects at a total cost of \$13,617,219, including federal contribution of \$6,839,349 and designed to supply 939 additional beds.

Two projects which had been approved, but are not yet under construction, involved a total cost of \$8,280,142, including \$5,382,856 federal contribution, and representing 410 additional beds.

It is interesting to note that according to the above figures, there are, or will be in the reasonably near future, a total of 2,180 additional hospital beds in South Carolina as the direct result of the funds supplied under the provisions of the Hill-Burton Act.



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MAUDE CALLEN STORY IN LIFE MAGAZINE ATTRACTS ATTENTION*

The story of the life of Nurse Maude Callen appearing in the December issue of Life Magazine is attracting nation-wide attention. Naturally, the people in Berkeley County, many of them, knew of the work being done, but at the same time there was a rush for Life and the supply soon was exhausted.

Reports are that letters containing contributions to Maude's work are coming in by the dozens every day—some of them substantial, though the total received to date is still unknown. For many years Maude has worked under handicaps, but her success has been outstanding. She is highly respected by her own people and by all of the white race who know her.


*From the Berkeley Democrat, Conway, S. C., December 4, 1951.

Respected, not only for her ability, but for the faithful manner in which she has gone about serving the sick and helpless when needed, day or night. She works under the County Health Department and no one appreciates her work more than does Dr. Fishburne.

Maude has wanted a Health Clinic for many years. It could be that the interest created by the story in Life may bring in the necessary funds. A further report will be made when the total contributions is determined.

In a wire to Dr. Fishburne, the Life representative who visited the county, took the pictures and assembled the facts, said in part: "It was one of the wonderful experiences of my life and I feel I have a stake in Berkeley County. I hope the story will prove of value to you and to the legislature. I sincerely thank you, Miss Baskin, and everyone for the depth of kindness and help I received."

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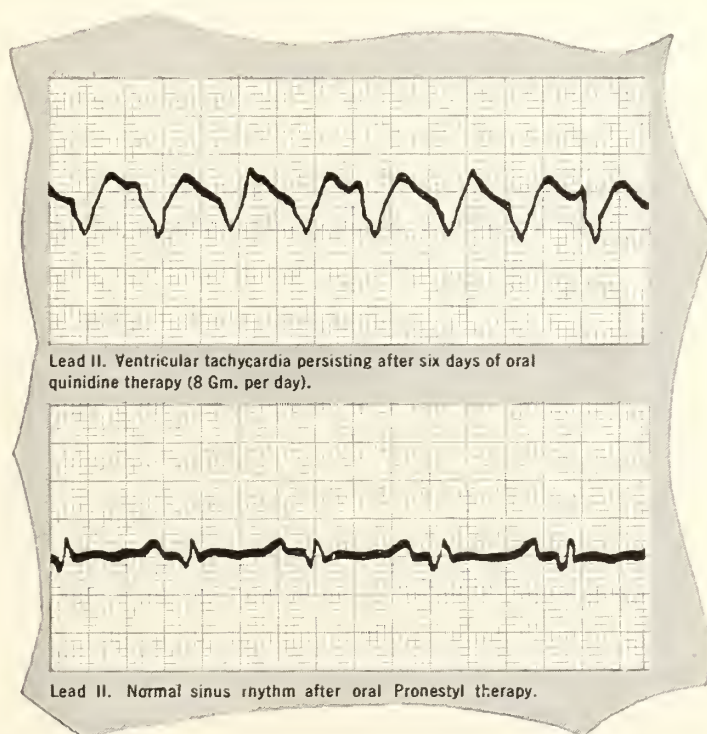
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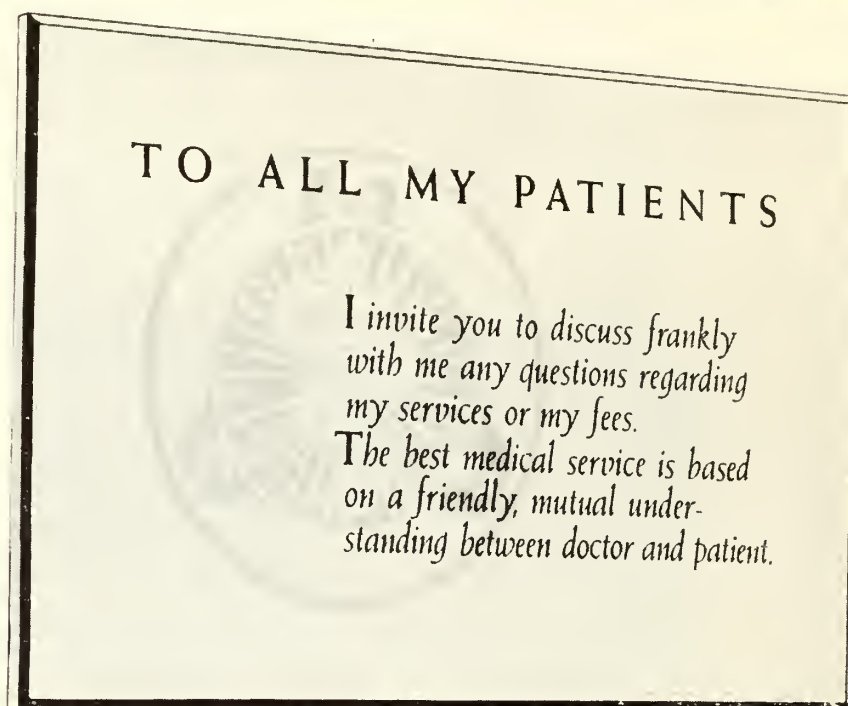
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A Report of A Case With Reference to the Hazards of Sensitization Arising From Topical Medication

VINCE MOSELEY, M. D. FACP AND SIDNEY PRYSTOWSKY, M. D.*

Contact Dermatitis is that form of dermatitis characterized by the allergic response of the epidermis to non-caustic substances in contact with it. The hallmark of the response is erythema and vesicles, explained by an acute superficial vascular dilatation with ensuing serous fluid escape into the epidermis. Spongiosis is followed by vesicles, which on bursting create the weeping and crusting lesion. After the coalescence of vesicles, bullae form. With prolonged and chronic exposure lichenification may occur, though always of a superficial type and unattached to the deeper layers of the integument in contrast to an atopic dermatitis. Thereafter scaling and fissuring may appear. The subjective itching and burning are accounted for by the increased tension from the exuded fluid on the sensory nerve endings in the skin.^{1 2 3}

Although contact dermatitis is classified as a disease of allergy, it differs from the other diseases of allergy, the atopic group, in that no antibodies can be demonstrated in the blood stream, and in that the sensitivity is limited only to the epidermis and spreads only to other epidermal areas, either by accidental transportation of the contactant by the hands or by the routes offered by skin lymphatics, which is a theoretical and unproved method of spread. Contact and atopic dermatitis may coexist in the same individual, but this is usually not the case as their mechanisms of pathogenesis are thought to be different. Some doubt, however, has been thrown on this postulate that contact and atopic dermatitis are unrelated by the experiments of Landsteiner and Jacobs.⁴ After sensitizing guinea pigs with p-chlorobenzoyl chloride, they obtained local reactions after application of that substance and typical anaphylactic shock after intravenous injection of a compound of p-chlorobenzoyl chloride and guinea pig serum. Occasionally, the ingestion of a substance may produce a contact dermatitis, but this is usually explained by an internal contact with the sensitized epidermis. Because of the site and mechanism of the sensitivity, it is understandable why intradermal scratch, or the Prausnitz-

Kustner methods for detecting the antigen are not useful. Instead, the patch test is used. The suspected contactant is placed against the skin, for days if necessary. Best results are obtained by placing the patch test as near the area of acute reaction as possible. The techniques and dilution strengths and vehicles listed in standard texts of allergy and dermatology should be employed. These precautions are necessary to avoid the false negatives due to too great a distance of the patch away from the restricted site of sensitivity, and false positive tests may be due to the use of solutions of such concentrations as to be classified as chemical irritants. A note of warning must also be sounded here against promiscuous patch testing because of the great likelihood of creating additional skin sensitivities in an individual; furthermore, generalized eczematous eruptions may also follow the performance of a patch test.

In addition to the symptoms, the appearance of the skin changes, as previously outlined, and the use of the patch test; there are other significant points that relate to the diagnosis. The site of involvement is a clue. Most contactants, such as fabrics, shoes, socks, watch bands, garters, zippers, ointments, toilet seats, adhesive tape, nail polish, lipstick, etc. have characteristic sites of involvement. This primary distribution is often complicated by chance contacts, scratching, and general eruptions. The occupational and domestic history should be explored minutely. Hobbies should be discussed. Placing the date and recurrences of the lesions may be very helpful. For example, consider the case of a person with acute dermatitis of the hands only for the first day or two of the week, due to the ink of the rotogravure section of the Sunday paper. Yet, were the physician to be diligent in his investigation he might still find it difficult, if not impossible, to trace the offending substance. This is particularly true in the more chronic cases, where superimposed sensitizations or the delayed resolution of unhealthy skin may erase the diagnostic advantages of elimination trials.

As in other diseases, prevention plays an important role in therapy. Avoiding contact with easily

*From the department of medicine, Medical College of the State of South Carolina, Charleston, S. C.

sensitizing substances, such as plants or drugs, is wise. Avoiding unnecessary physical or chemical trauma to the skin lessens the likelihood of sensitivity developing because of a lessened chance for penetration of the natural protective oily coating of the epidermis. The degree of penetrative power and therefore sensitizing ability of substances depends on the alkaliability or lipid state, for example the lipid of the poison ivy plant. If the contactant is discovered, it may be removed from the patient's environment. At other times, it may be necessary to remove the patient from the environment of the contact, as in occupational cases. Desensitization therapy may be attempted; techniques and results differ. This has been tried in poison ivy dermatitis with reported conflicting results. It is important to be cognizant of the potentiality of spreading a contact dermatitis during such therapy. Suggestion has been made that daily application to the skin of increasing amounts of the antigen could be employed as a method of desensitization.

In all cases symptomatic care is indicated. Commonly accepted procedures are the use of calamine lotion, cool soaks, oatmeal baths, local analgesics, and sedatives during the acute stages, and particularly being certain that only the simpler, least probably sensitizing therapeutic agents are employed. In the later stages emollients of a simple nature are valuable to combat crusting and fissuring.

A brief list⁵ of the more frequent groups of materials producing contact dermatitis are:

1. Cosmetics: hair dyes, fur dyes, hair tonics, hair lacquers, bleaches, creams, depilatories, deodorants, nail polish, perfumes, soap, and hand lotions.
2. Clothes: wool, silk, rayon, nylon, aniline dyes and leather.
3. Botanicals: flowers, plants, weeds, insecticides.
4. Pocket or Jewelry Items: silver, nickel, rubber, tobacco and matches.
5. Medicinal Preparations: mercury, cresol, phenol, sulfur, resorcinol, quinine, sulfonamide drugs, local anesthetics, formaldehyde, picric acid, and medicated soaps.

This list is only partially indicative of the many types of substances which can cause contact dermatitis. In general, most any medicinal agent may be responsible, even epinephrine, our chief sheet anchor in treating the severe allergic reactions. As an example of a patient developing sensitivity to epinephrine, the following case is reported.

CASE REPORT:

The patient was a 63 year old white woman who was observed by both authors. She developed bronchial asthma after a pelvic operation 30 years previously, at which time she had a hysterectomy. During the past 30 years she had been seen by several internists and allergists without avail. During the past

several years she had become more comfortable with the use of an adrenalin spray ("Inhalant A").

A detailed asthma history afforded no clue to the allergen. The episodes were nonseasonal, and the only precipitating factors that she was aware of were emotional ones.

Complete scratch testing revealed slight reactions to dust and feathers. A feather pillow was thereafter removed from her room, and her home was made as dust proof as possible. Because of continuing attacks of asthma, desensitization to dust and feathers, starting with dilute solutions, was begun, but to no avail. It appeared that emotional factors contributed largely to her unresponsive asthmatic state.

At this point she complained of an itching and redness on the left lower eyelid that soon involved the entire left eyelid and the left cheek area. Within a matter of days the right eyelid also became involved. There was a salmon pink hue of the involved areas, a slight thickening of the involved skin, slight scaling, and fissuring at the outer canthus of the left eye. All facial cosmetics and nail polish were avoided. "Pyribenzamine" cream applied locally gave relief. After observing the patient's method of using the spray inhalation, it was discovered that she sprayed as much solution about the face as entered the oral cavity. "Inhalant A" was then suspected as the antigenic substance, and patch testing revealed it to be the offender. This preparation is composed of an aqueous solution of epinephrine and the preservative, chlorbutanol. Patch testing to chlorbutanol was negative, to "Inhalant A" positive, and to "Isuprel" ("Isuprel" plus chlorbutanol) negative. The conclusion that she had a contact dermatitis from the epinephrine in the spray was reached. The results of the patch testing also suggested the desirability of a trial with "Isuprel" as a substitute, if her asthmatic state necessitated it. A Prausnitz-Küstner reaction was negative. She was benefitted less on "Isuprel" than on "Inhalant A" and therefore desensitization to epinephrine was started. After proper instruction, she administered 1:1,000,000 epinephrine subcutaneously on her right thigh, 0.1 c.c. 1st day, 0.2 c.c. 2nd day, and noted the next day small papules and itching at the sites of injection. The lesions became larger and began to ache in spite of the discontinuance of the epinephrine injections. They disappeared slowly over a 2 to 3 week period while the patient was on antihistaminics. After disappearance of the lesions, epinephrine was administered intramuscularly, and a small amount of air was injected through the needle before withdrawing it. After 3 weeks of gradual increase from 0.1 c.c. of 1:1,000,000 epinephrine to 0.7 c.c. of 1:1,000,000 epinephrine in the manner described above, the epinephrine being given in the left thigh always, again there developed eruptions at the site of the previously self-administered epinephrine in the right thigh, as well as on the left arm in the antecubital fossa area; the lesions were of a pruritic, papulo-

vasicular type. Before they disappeared, a crop of these lesions also developed in the right antecubital area. No local therapy was given. Desensitization was started again at 0.1c.c., 1:1,000,000 and was carried through 1.0c.c., 1:1,000,000, without untoward results.

Three days before expected company she developed marked asthma again, and emotional factors seeming so strong in her case, a neuro-psychiatric approach was then begun and further attempts at desensitization were not continued.

Only relatively infrequently does one come across references to contact dermatitis in medical journals other than those devoted to the specialties of dermatology and allergy. In order, therefore, to emphasize and to picture properly the expanse of this subject a review of representative general and special journals is now given.

A 12 months review (Jan. '49-Jan. '50) of the Archives of Dermatology and Syphilology (8) and the Journal of Investigative Dermatology (9) revealed 22 articles relevant to contact sensitivity. The substances mentioned are "antistine," penicillin, compound tincture of benzoin, yellow azo dye of artificially colored oranges and nembutal capsules, procain in procaine penicillin, procaine as a local anesthetic, DDT in a spray, "pyribenzamine" ointment, "saligenin" (phenol-formaldehyde resin), garlic, nylon hair nets, footwear, wax crayons, "streptomycin," "bacitracin," sulfonamides, nail polishes, 0.2% phenolphthalein in denatured alcohol, mercury, and "theophorin."

A 12 months review (Jan. '49 to Jan. '50) of the Journal of Allergy (10) revealed 33 abstracted articles relating to contact dermatitis. They dealt with contact dermatitis due to "butesin," "pyribenzamine," penicillin, the cosmetic "Everon," "tyrothricin," "streptomycin," the carpet beetle, the abdominal hairs of the female moth, finger paints, "sulfathiazole," "intracaine," 10% sodium "sulfacetamide," a scarf or a tree trunk lichen in a woodcutter, seaweed in a fisherman, the monoglycerol para-aminobenzoate filter of sunburn lotions, resins, invisible ink, "pontocaine" organomercurials about surgical wounds, a 14-carat gold ball in an enucleated eye, house ivy dermatitis, atropine in eyes, and synthetic rubber.

In contrast, a 12 months review (Jan. '49 - Jan. '50) of the Journal of The American Medical Association (11) revealed only 10 references to contact dermatitis, only three in article form, two in the abstracts, and five in the Queries and Minor Notes. They mentioned rubber gloves, the synthetic resins of shirt finish, gasoline as a solvent, "tyrothricin," polyvalent antibiotic sensitivities, organo-mercurial compounds, turpentine, and the antihistaminics.

These differences are cited to indicate that the problem of contact dermatitis is a frequent and wide-

spread one but, unfortunately, one which only those especially interested in allergy or dermatology seem to be especially cognizant of.

The brief mentioning of these articles should suggest the need of a high index of suspicion in order to effectively treat the patient and also to be especially aware of this possibility and thus try to prevent iatrogenic skin lesions. The frequent reference in journals of dermatology and allergy to contact dermatitis should, along with our own case report, emphasize the potential dangers of topical therapy and drug handling, and the need to avoid unnecessary exposure. There is no denying the universality of potentially sensitizing and cross-sensitizing drugs and, therefore, of the difficulty in avoiding their use. However, we could at least insure the safekeeping of potent and valuable drugs for future more important needs.

Especially imperative because of their ease of sensitization and polyvalent sensitization are the local anesthetics, certain of the antibiotics, and the sulfonamides. Albright and Sereton¹² reported the case of a wounded sailor previously treated with sulfanilamide. Within 24 hours after the use of 5% sulfathiazole ointment on the eye, he developed local and general reactions, viz., edema and chemosis of the eyes, general urticaria and itching, necrosis of the wounds previously treated with sulfanilamide, and a fall in blood pressure. Wilson¹³ reported a patient receiving penicillin parenterally for a nonocular infection after having previously received local penicillin for his eye. He developed an allergic swelling of the previously treated eye. Riley¹⁴ in a recent article referred to the desirability of avoiding the local use of penicillin and streptomycin because of sensitization hazards. Case reports and articles such as these seem to make it advisable to avoid promiscuous topical use of drugs as potentially important and as easily sensitizing as are those mentioned, and preferably, to substitute drugs not advised for systemic therapy and drugs of lesser sensitizing ability.

A recent report¹⁵ emphasizes the efficient bactericidal and the very low allergenic quality of topical "bacitracin" therapy. Another author¹⁶ reported a 0.5% local sensitization record for "bacitracin" in contrast to a 5-10% local sensitization record for penicillin and the sulfonamides. Tyrothricin too, has been mentioned as a favorable drug for topical antibiotic therapy.^{17,18,19,20} Although case reports of sensitization to it have appeared, it is considered to have a relatively low sensitization index. Furthermore, it is unfavorable for systemic therapy. Here, therefore, are logical substitutes for penicillin and the sulfonamides, their antibacterial spectra being very similar. With further purification "bacitracin" may be of use also as a systemic antibiotic.^{21,22} Should this occur it, too, should be protected from a future made dangerous by topical sensitization. At present, there is much hesitation in the systemic use of "neomycin" because of eighth nerve damage and nephrotoxicity. This per-

mits, therefore, a correspondingly lesser hesitation in its topical use. Its effectiveness against both gram positive and gram negative organisms, its stability, and its reputed low sensitivity index are all favorable factors. The polymyxins^{2,3} are other antibiotics that have been found effective against gram negative organisms, but they are also reported to cause nephrotoxicity and, to some extent, a neurotoxicity. It remains for the future to determine whether they can achieve a place as safe systemic antibiotics. At present certain members of this group should be confined to local use only, and thus are potent topical medicaments to add to the list already mentioned. It would be incomplete not to mention the availability still of the older more well known antibacterial medicaments, long used for topical purposes, such as alcohol, "hexylresorcinol," boric acid, iodine, chlorine, the peroxides, potassium permanganate, the mercurials and the silver preparations, the zinc salts, copper salts, the dyes, "furacin," and numerous other chemicals. Some of these are easily sensitizing, others weak, some limited to the gram positive organisms, others irritating, etc. However in the usual instance, antibiotics will perform no greater service locally than many of these older preparations.

Lane and Luikart²⁴ recently indicated the frequent potential hazard of contact and polyvalent sensitivity in the use of local anesthetics. Like others they have become aware of the aggravation of the original condition with the development of an overlying contact dermatitis. In the discussion following, Osborne²⁵ stated that 40-50% of cases of contact dermatitis are due to drugs, between 10-20% being due to local anesthetics. Pillsbury²⁶ contrasts the slim evidence of the ability of topical anesthetics to relieve skin itching or pain with the undoubted evidence of their sensitizing ability. Luikart, in closing the discussion of his paper, pointed out that the ointment bases are the usual vehicles of topical anesthetics and that they aggravate a pruritis by reason of the retention of skin heat. It follows that wise restriction in the use of topical anesthetics will result in fewer and less severe cases of contact dermatitis without compromising much in the way of therapeutics.

SUMMARY AND CONCLUSIONS

Throughout this paper stress has been placed on the potential hazards of topical therapy. To our knowledge this is the first report of a patient developing a contact dermatitis to epinephrine. This observation that epinephrine, as well as many of the antihistaminic drugs can sensitize the skin when applied locally indicates that caution, restriction, and awareness of this complication should be had by anyone who prescribes any drug for topical therapy.

A search of the literature uncovered no previous report of a contact dermatitis due to epinephrine. Both Cohen and Waterstone⁶ and Rowe and Rowe⁷ reported the Arthus phenomenon after repeated epinephrine injections, the flare-up of previously injected

sites through the stages of redness, swelling, sloughing, and scarring. Cohen and Waterstone⁶ also reported a Schwartzman reaction after repeated epinephrine injections. After subcutaneous administration had been repeatedly given; the reaction occurred upon intravenous administration. It is interesting to note that synthetic epinephrine, they report, did not produce such a result. The comparison with the thigh eruptions in our case is striking, and the possibility of substituting synthetic (Winthrop) epinephrine for the usual commercial epinephrine in all inhalant type sprays or topical forms is an intriguing and perhaps desirable goal. The development of the lesions observed in our patient during the course of desensitization with epinephrine on two occasions suggests that these were either lesions of contact dermatitis with the antigen reaching the epidermis via internal routes to produce both the recurrence of lesions on the thigh and the papulo-vesicular eruption on the elbows, or an atopic dermatitis which developed during attempts at desensitization. The latter postulate explains the development of lesions at the flexural elbow areas, and the incomplete Arthus phenomenon-like reaction on the thigh. The absence of a recurrence at the original site of the contact dermatitis on the eyelids mitigates somewhat against the former postulate. The fact that only a relatively small percentage of patients with atopic allergy have positive Prausnitz-Küstner reaction does not, therefore, necessarily discredit the possibility of atopic dermatitis, and it is, therefore, entirely tenable to believe that this patient exhibited both types of allergic dermatitis — first a contact dermatitis, and later atopic dermatitis, both due to epinephrine.

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Relief of Impotency by Cartilage Implants: Presentation of A Technic

BUFORD S. CHAPPELL, M. D.*
Columbia, S. C.

The successful sex act depends upon two perfectly intergrated factors: A) sexual desire or libido and B) ability to effect and maintain an erection. Dysfunction will result from interference with one or both of these factors. Loss of sexual ability is an inherent feature of growing old. Long, chronic and debilitating illness may reduce the sexual desire or libido. Often the loss of desire is the manifestation of a sick or diseased mind and is here the province of the psychiatrist. Sexual intercourse without desire is a tasteless act; desire without ability is a disaster accompanied by severe psychic trauma and often by mental aberrations of terrifying proportions. It is apparent then, that if sexual desire remains, something might be done to give erectness and substance to the penis, permitting the introduction of the penis and the successful performance of the sex act. During World War II, the Russians (1) received considerable newspaper publicity for their reconstructive surgery of the penis. They utilized cartilage grafts wrapped in tube grafts of skin and claimed excellent results. While not accepting their results in their entirety, it seemed that cartilage did offer the best material for implantation into the penis because of the diminished foreign body reaction and because the cartilage was semirigid and elastic and would give substance and erectness to the penis without the disadvantage of an inflexible rigidity. Certainly a very rigid organ would be uncomfortable to both sex partners and not without danger to the woman. These desirable qualities of cartilage were ap-

preciated by at least one American surgical team (2) who used cartilage implants to correct impotency in a soldier who had suffered injury to his penis, specifically to the corpora cavernosa. Considerable plastic reconstruction was also necessary in their reported case.

We believed that if cartilage implants could prove successful in aiding sexual activity where plastic reconstruction of the penis was necessary, they could be utilized to aid the patient in whom no such extensive surgery was necessary, provided he retained his sexual desire and a good mental outlook. I believe it worthwhile to emphasize the necessity of evaluating the patient's mental status. If there is too much preoccupation with his sex failures, if patient is not extremely cooperative and at least moderately intelligent, I believe the operation should not be done. The patient should be carefully screened for latent psychosis since surgery of any sort upon the genitalia of a psychotic, or potentially psychotic patient is dangerous—and sometimes fatal to the surgeon.

Since the previously described technics were adaptable primarily to those cases in which plastic reconstruction was to be carried out, they did not suit our needs and a more suitable operation had to be devised. A study of figure 1 will show that the penis is made up essentially of three erectile bodies, the paired corpora cavernosa and the single corpus spongiosum. These are individually invested with a thick tough coat, the tunica albuginea, and collectively by the thick Buck's fascia. The skin and the superficial fascia complete the coverings of the penis. The large nerves and vessels course along the dorsum of the penis. A pair of natural grooves or depressions are

*Attending Urologist, Veteran's Administration Hospital, Columbia, S. C.

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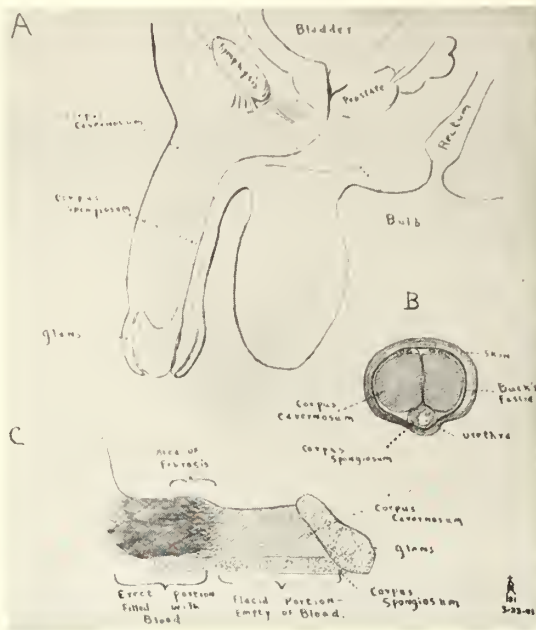


FIGURE 1. A—schematic representation of the penis in sagittal section showing the erectile tissue of the corpora and the fixation of the base of the penis. B—shows the penis in cross section. C—shows schematically what happens when the corpora are obstructed or obliterated.

present on the ventral surface of the penis and are accentuated when the penis is erect or a sound is passed into the urethra. To prevent undue distortion of the penis and in order to protect the large nerves and vessels of the dorsum of the penis, the most logical position for the implantation is in these depressions on the ventral surface of the penis. On the ventral surface of the penis, the grafts would be under, rather than on top of—or to the side of the corpora cavernosa and the support would be more natural and there would be less tendency for the grafts to slip. It can also be seen by reference to figure 1, that the base of the penis is fixed, but that the rest of the penis is made erect by the filling of the blood spaces in the corpora and that the penis would be flaccid distally to any injury or obstruction to the filling of the corpora. The supporting bridge of cartilage must therefore extend from the normally erectile tissue to the distal end of the penis. The penis must also allow for the comfortable and inconspicuous wearing of clothing.

The technic and principles of the operation can best be presented by an illustrative case: W.F.W., a 23 year old Negro, veteran of World War II was admitted to the Veteran's Administration Hospital, Columbia, S. C. on May 3, 1949 with a severe priapism of 48 hours duration. All conservative measures failed to relieve the painful erection and on the seventh day after admission, incision and drainage of the right corpus cavernosum was carried out with gradual subsiding of the priapism. Complete, exhaustive and re-

peated studies failed to establish the cause of the priapism. Three months later, he was readmitted greatly distressed over his inability to have sexual intercourse. Examination revealed the healed scar of the incision into the right corpus cavernosum. There was a band-like constriction around the base of the penis and manual manipulation of the penis by the patient failed to cause any visible or palpable erection of the penis. He retained his normal sexual desire but at no time could he effect an erection of the penis and no portion of the shaft seemed to respond. On Nov. 16, 1949, almost five months after the priapism had subsided, the first stage of a two stage operative procedure was carried out. Figures 2 & 3. An incision

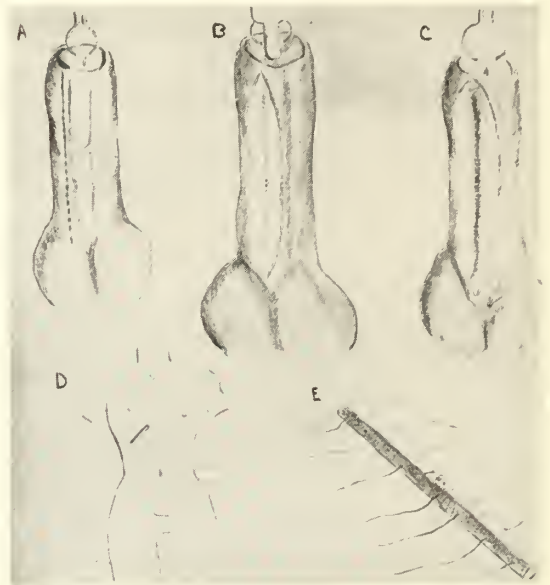


FIGURE 2. A—incision on the ventral surface of the penis to right of midline. B—skin incision has been made and Buck's fascia can be seen. C—Buck's fascia has been incised and the trough between corpora cavernosum and spongiosum is being deepened. D—shows donor site for cartilage graft. E—shows the prepared cartilage graft with the silk sutures in place.

was made on the ventral surface of the penis extending from the corona well back over the base of the penis and just to the right of the midline. The skin incision was deepened through the subcutaneous tissue and superficial fascia. Buck's fascia was incised in the depression between the right corpus cavernosum and the corpus spongiosum. By careful dissection, and using a sound in the urethra to bring the corpus spongiosum into prominence, a deep trough was prepared between the corpus spongiosum and the right corpus cavernosum to receive the cartilage graft. The longest single relatively straight piece of cartilage that could be obtained was only about six centimeters long and it was immediately apparent that this cartilage would not completely bridge the entire undersurface of the penis. A similar length of cartilage was then obtained and the two pieces spliced together by cutting

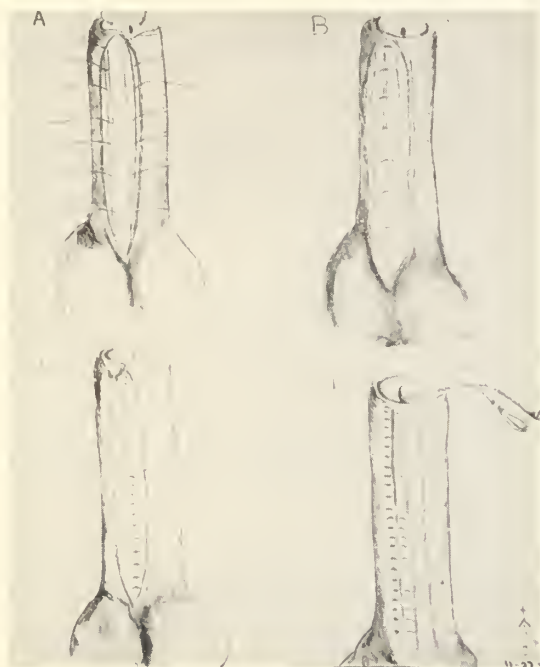


FIGURE 3. A—shows the cartilage in place in the prepared trough with the silk sutures brought out through the tunica but not yet tied. B—the sutures have been tied and the cartilage almost completely buried. C—Buck's fascia has been sutured. D—the skin has been closed and a catheter is in the urethra.

both pieces on a very slanting bias and then suturing the two together with several interrupted sutures of very fine silk. There resulted a straight length of cartilage approximately eight centimeters in length. The cartilage was now pared to remove irregularities and to give it a rounded, triangular shape to fit into the prepared trough. Fine silk sutures were then placed through the cartilage at one centimeter intervals. The implant was now placed into the prepared trough so that the proximal end of the graft lay well back over the base of the penis and behind the level of the symphysis pubis and so that it would rest on the fixed portion of the penis. The distal end was capped by the glans penis. The sutures already placed in the cartilage were now brought out through the adjacent tough tunica albuginea of the corpus cavernosum and spongiosum and tied. To our pleasure the sutures could be tied with no tension and with almost complete burying of the implant. Buck's fascia was now approximated using interrupted sutures of very fine silk. The skin and subcutaneous tissues were closed with interrupted mattress sutures of very fine silk. Frequently during the placing and suturing into place of the graft, we tested the urethra for pressure deformity and there was none. A suture was placed through the glans and the penis suspended to a heat cradle by rubber bands. A 22 F. Foley bag catheter was left in for bladder drainage. Four days post-operatively, the original dressings were changed and on the seventh post-operative day, the sutures were removed. Two weeks

post-operatively, he was allowed to go home and shortly afterwards successfully performed sexual intercourse. A long redundant foreskin interfered and patient used a condom to hold back the foreskin and to lend support to his penis. He returned to the hospital much more cheerful and in much better spirits and was anxious to have the second stage procedure done. Approximately six weeks after the first operation, an operation identical in principle with the first one was performed. During his first admission and while the cause for his priapism was being investigated, he was found to have a moderate diverticulum of the more distal portion of his penile urethra. This was inadvertently entered during the course of the second operation and a perineal urethrostomy done to divert the urine. There were no ill effects and healing was uncomplicated and uneventful.

The ability to have intercourse was much improved by the second operation but the long foreskin still hampered coitus and a cuff type of circumcision was performed. The penis now hung in a semi-erect position that allowed the comfortable wearing of clothing but the penis retained enough rigidity and substance to allow successful intercourse. Figure 4.

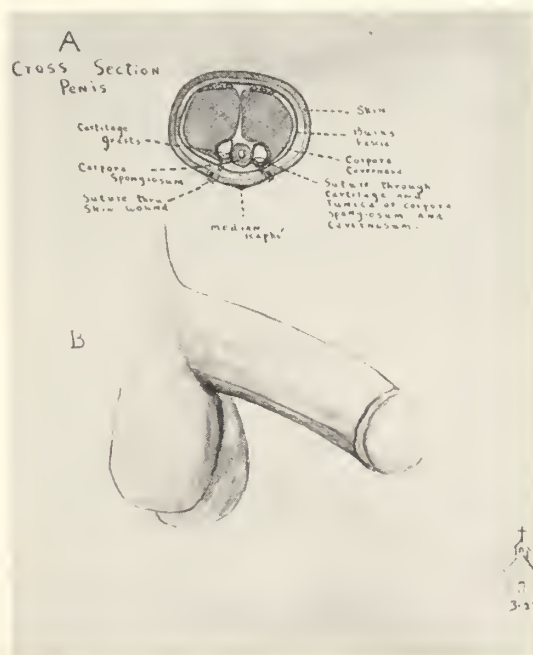


FIGURE 4. A—cross section of the penis showing the position of the cartilage implants. B—is the penis following surgery showing the semi-erect position.

Patient followed for a year and has continued to have successful intercourse without destruction or absorption of the cartilages. He has ejaculations although intercourse is not as pleasant as before the priapism.

SUMMARY:

A technic for the transplanting of cartilage into the penis, in a two stage operation, for the relief of impotency is presented.

Although cartilage implants have been used for similar purposes in plastic restorations of the penis, we know of no report of the relief of impotency of the type caused by priapism by cartilage implants. We believe our method of implantation to be original and to have certain advantages over the methods of implantation reported by Frumkin¹ and Solomon and Karleen² in their reported cases of plastic restorations of the penis.

We wish to present this as a useful operation particularly adaptable to impotency of the type following priapism and for other causes where there has

been injury to or obliteration of the erectile tissue. Sexual desire must be retained and the mental attitude of the patient must be good. It is not suggested for use in impotency of older patients.

Finally I want to publicly thank Dr. T. M. Yates, for his facilitation of the operation by the obtaining of the cartilage grafts for me and allowing me to thereby devote my full attention to the other features of the operation.

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Dietary Problems in South Carolina

ADA M. MOSER, *Home Economist*
South Carolina Agricultural Experiment Station
Rock Hill, S. C.

(We publish this article for two reasons. It contains information which should be of concern to all those who are concerned with the problem of nutrition in the people of South Carolina. It shows what individuals and organizations outside of the medical profession are thinking and doing in this field. Clemson and Winthrop Colleges, through their various agencies, are doing work of paramount importance in the field of nutrition and we believe their work should be recognized and appreciated more by the members of our Association. Editor.)

Farm Family Diets

Studies made by the Experiment Station over a period of twenty years have shown that farm families in the state produce an important part of their food supply especially the valuable protective foods, milk, green vegetables, eggs.¹ In general, farm families had very poor supplies of these foods if they did not produce them in satisfactory quantities.

These studies show differences in the diet patterns between Piedmont and Coastal Plains. Farm families in the low country, in general, used more meat, poultry, and fish and less milk than did up-country families. Piedmont farm families produced a larger share of their food than did those in Coastal areas. With increase in industrialization, especially in the Piedmont, many families living on farms no longer rely on farming for most of their income; one or more members work in town and the family often buys the greater part of its food supply. This changing pattern of living, no doubt, is having marked effects on the diets of rural families.

The most recent food consumption study in the state was made in the late winter and early spring of 1948 in the tobacco farming section. It was part of a Southern cooperative study of farm family diets in three types of farming areas, the results of which have not yet been published. Home Economists of the Experiment Station obtained weekly food records in Horry, Marion, Florence, and Williamsburg Counties from 149 families containing a man, wife, and one or more children two to 18 years of age. The sample represented the race and tenure groups in approximately their actual proportions.

During the previous year, 1947, the estimated cost of food was \$567 for white owners, \$488 for white share croppers, and \$331 for negro share croppers; for the same groups home-produced foods had a farm value of \$785, \$375, and \$311 respectively.² Most of the families produced eggs, pork, potatoes, cornmeal, and some garden vegetables. Only 55 percent of them had any home-produced milk the previous year. According to the 1940 Census 47 percent of the farm families in the four counties reported cows milked in 1939. The 1948 study indicates that very little, if any, increase had taken place in the proportion of families having their own milk supply, even though commercial milk production in the area may have increased.

During the week in which the food record was kept, in February, March, or April, 1948, the consumption of all forms of milk, cream, ice cream and cheese (reduced to an equivalent in fluid milk) was as follows:³

<i>Quantity of milk per person per day</i>	<i>Percentage having</i>
None	13
Less than 1 cup	43
1 cup, less than 2 cups	20
2 cups, less than 4 cups	17
4 cups or more	7

The consumption of meat (largely pork), eggs, and cereal foods was relatively high, but not of vegetables and fruits, as the following summary indicates:

<i>Pounds per person in a week</i>	<i>Percentage having</i>
Tomatoes and citrus fruit:	
None	29
0.1-0.4	25
0.5-0.9	22
1.0 and over	24
Green and yellow vegetables:	
None	19
Less than 1.0	47
1.0 and over	34
Potatoes, Irish and sweet:	
None	34
0.1-0.9	29
1.0 and over	37

The nutritive values of these diets were calculated and compared with allowances of each of nine nutrients recommended by the National Research Council. Iron, thiamine, and niacin were seldom below these allowances. Use of enriched grain products by these families was largely responsible for this showing. Fifty-five percent of all grain products had been enriched by addition of iron, thiamine, riboflavin, and niacin. These additions provided, at the family income level of \$500 to \$999 a year, about one-third of the daily iron, almost one-third of the riboflavin, somewhat over one-third of the niacin, and over one-half of the thiamine allowance recommended by the NRC. In spite of enrichment, about a third of the families in this income group failed to get as much riboflavin as the recommended allowance.

Taking all families together, approximately two-thirds failed to get as much ascorbic acid and calcium as the NRC recommends. About one-fifth had 25 grams or less per person per day of ascorbic acid (1/3 of the allowance), and one-sixth had less than half the recommended allowance of calcium. A good share of the calcium was derived from self-rising flour. Vitamin A values were also low in many instances; only about half of the family diets furnished as much as the recommended allowance.

The influence of the season should be recognized. Meat and eggs were at or near their peak of supply, but potatoes and other vegetables and fruits were probably at their lowest level. In the fall, when sweet

potatoes are generally used, the vitamin A values would have been much higher. Ascorbic acid would have been in better supply in summer and fall. However, the amounts of calcium and riboflavin would, no doubt, have been below the desired levels at any season in families where no milk was produced.

Diets of Nonfarm Families

There is reason to believe that nonfarm families, even if they have higher cash incomes than do farmers, are less well supplied with protective foods than are farm families. Dr. Price reported that more malnutrition has been observed in families of textile workers, especially where both the man and wife work, than among farm families.⁴ No doubt poor diets are at least partially to blame for this condition.

Nutritional Status of Population Groups

Dietary studies give only indirect evidence regarding nutritional problems, but they indicate the need for educational work and other measures for improvement of food intake, one of the major factors in maintaining good nutritional status. A study of the effect of a well planned school lunch on the nutritional condition of school children showed that improvement in the nutritive value of the day's meals was accompanied by increased growth rates and other signs of well being.⁵

Observations by private physicians and public health consultants show that malnutrition and poor food habits are still problems facing the people of the state;⁶

The Challenge

These facts present a challenge to educators. One of the difficult problems is how to bring about desirable changes in food habits. The conflict between traditional food customs, on one hand, and ideas derived from the science of nutrition on the other, is evident whenever an effort is made to improve food habits through education.⁷ One of the big tasks in teaching is to make foods "good for" one seem also good to eat.

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CANCER

Edited by HENRY W. MAYO, JR., M.D., Charleston, S. C.

CARCINOMA OF THE ESOPHAGUS

By

CHARLES B. HANNA, M. D., Spartanburg, S. C.

EDWARD F. PARKER, M. D., Charleston, S. C.

R. W. POSTLETHWAIT, M. D., Kinston, N. C.

AND

R. H. BURLEY, A. B., Charleston, S. C.

This paper consists of a review of all cases of epidermoid carcinoma of the esophagus seen in the Roper Hospital and the Cancer Clinic of the Medical College of the State of South Carolina during the 11½ year period, January 1, 1940 to June 30, 1951. There have been 170 cases with histological proof of the diagnosis of epidermoid carcinoma. During this same period, there were seven cases of primary carcinoma of the stomach with invasion of the lower end of the esophagus, which cases have been excluded from the review.

Many studies have been made of the incidence of carcinoma of the esophagus compared to that of the stomach and large bowel. These studies indicate that in general carcinoma of the esophagus occurs less often than carcinoma of the other portions of the alimentary tract. It is known, however, that certain countries and localities have a higher incidence of esophageal carcinoma, in particular the Scandinavian countries, China¹ and other parts of the Orient and Curacao.² It has been our observation that also in this locality carcinoma of the esophagus occurs more frequently than that of the stomach or large bowel.

Table I shows that there were 155 cases of esophageal carcinoma, 146 cases of carcinoma of the stomach³ and 103 cases of carcinoma of the colon and rectum⁴ during an 11 year period at this clinic.



DISTRIBUTION OF CARCINOMA OF THE ESOPHAGUS SEEN IN THE CANCER CLINIC OF THE MEDICAL COLLEGE OF THE STATE OF SOUTH CAROLINA AND ROPER HOSPITAL
JAN 1, 1940 - JUNE 30, 1951
170 CASES

Map I shows the distribution of the 170 cases of esophageal carcinoma among the counties of South Carolina. It is evident that the large majority were from Charleston.

Ackernan and del Regato⁶ write that most esophageal cancer is in individuals 40 to 60 years of age. Table II shows that 96 of our cases (56.8%) occurred between 40 and 59 years of age. Nineteen cases (11.2%) occurred under the age of 40, and 54 cases (32.0%) occurred at 60 years of age and above.

Table III shows that 145 cases (86%) of this series were Negroes and 25 (14%) were white. Of the Negroes 82 were males and 63 females, about a 4:3 ratio. Among the white cases, there were 14 males and 11 females.

Table IV shows an analysis of the symptoms in the 170 cases. Dysphagia was the most common complaint. Closely following dysphagia was weight loss, often far out of proportion to the degree and duration of esophageal obstruction. The next most common complaint was pain, usually referable to the level of obstruction. Regurgitation, cough and hoarseness were complaints indicating advanced carcinoma. Less common findings are listed as a footnote.

Table V shows the duration of symptoms among the 170 cases. In many the diagnosis was established reasonably early; this was considered to be so in those 69 cases (40.7%) having symptoms of two months or lesser duration. In analyzing the records of those cases with symptoms of three weeks or lesser duration, it was learned that the operability and resectability rates were no more favorable than in those with symptoms of longer duration. It was considered that the diagnosis was established late in 101 cases (59.3%). In studying the records of the 101 cases with symptoms of two months or greater duration in order to try to find where to place the blame for late diagnosis, it was learned that the fault lay more often with the physician than with the patient. Most patients consulted one or more doctors soon after the onset of symptoms. Most physicians including those on our own staff, failed to suspect the possibility of carcinoma of the esophagus, even in the presence of persisting and increasingly severe dysphagia, until late in the course of the disease. The average duration of patients with carcinoma of the esophagus is shorter than in those with carcinoma of the stomach or large bowel, as evidenced by the fact that only 3 of the 170 cases had symptoms of twelve months or greater duration.

The most common physical findings are listed in Table VI in the order of their frequency. Often the

emaciation was so advanced that it alone contra-indicated operation.

The majority of these cases had their weights recorded. There was an average loss of 34 pounds, or 23% of the total body weight, with extremes ranging from 1% to 54%. The varying degrees of esophageal obstruction and duration of dysphagia influenced markedly the degrees of electrolyte imbalance seen. As would be expected, there were variations from normal hydration to advanced dehydration and starvation. There was almost always anemia associated with the diminished or absent food intake. This offered a serious problem which was usually helped by multiple transfusions, but occasional cases did not respond to any replacement therapy. The cervical lymphadenopathy, hoarseness, and cough on swallowing water were found in the cases with advanced disease.

The diagnosis was established by esophagoscopy and biopsy in most cases. In some, in whom esophagoscopy was not performed because of refusal or because of the moribund state of the patient upon admission or other reasons, the diagnosis was established by autopsy. Esophagoscopy, in addition to being essential for establishing the diagnosis in any case considered to be a candidate for operation or other rational therapy, also afforded opportunity to ascertain the uppermost level of the tumor, some of its characteristics, and in some cases the length of esophagus involved.

The uppermost level of the lesion was determined in 159 cases by esophagoscopy, operation, or autopsy. In these, it was found to be in the cervical esophagus in 17 cases (10.7%), in the upper fourth of the thoracic esophagus in 11 cases (6.9%), in the middle half of the thoracic esophagus in 110 cases (69.2%), and in the lower fourth of the thoracic esophagus in 21 cases (13.2%).

Additional studies considered essential in any patient with known or suspected carcinoma of the esophagus included radiographic examinations of the esophagus and upper gastro-intestinal tract using barium, radiographic examinations of the chest, laryngoscopy, bronchoscopy and biopsy of any palpable lymph nodes possibly the site of the metastases. In 11 cases, invasion of the lower end of the trachea or a main bronchus, with or without a fistula between the esophagus and tracheo-bronchial tree, was found by bronchoscopy.

Table VII shows the incidence of associated diseases. Of the six patients with other malignancies, one had carcinoma of the prostate, one had carcinoma of the cervix, two carcinoma of the breast, one malignant melanoma of the eye and one fibrosarcoma of the abdominal wall.

The results obtained in 109 of 114 inoperable cases are shown in Table VIII. The other 5 cases could not be followed. Forty-one cases received no treatment

(usually because of refusal or moribund on admission). In these 41 cases, the average time between the onset of symptoms and death was 7.5 months, with extremes of 15 days and 36 months. Fifty-three cases were treated by gastrostomy alone. In these 53 cases, the average time between the onset of symptoms and death was 9.8 months, with extremes of 2 months and 51 months. Of more significance was the average survival time from gastrostomy until death. In these 53 cases, it was 3.8 months, with extremes of 4 days and 35 months. The number of cases treated by other methods was too small to merit statistical evaluation, but when considered as a group the average survival time after the onset of symptoms and after the beginning of treatment approximated that in those cases in whom no treatment was used. The treatments used in conjunction with gastrostomy were podophyllotoxin locally, radioactive iodine and testosterone. It was felt that there was no true palliation achieved in any of the patients with gastrostomy. In general, they continued to lose weight and strength, despite some instances of transient improvement in the dysphagia. Usually, the gastrostomy seemed an added burden to the patients.

Fifty-six cases were operable. Of these 56 cases, 30 (54%) were resectable and 26 (46%) were non-resectable. Two of the non-resectable cases had cervical lesions and in these only tracheotomy was performed to relieve tracheal obstructions. All of the remaining 24 cases explored and found to be non-resectable had thoracic lesions. Four cases died following operation (15.4% of 26). Of the remaining 20 cases, 2 could not be followed. Gastrostomy in addition to exploratory thoracotomy was performed in 17 of the remaining 18 cases. All 18 cases died (Table IX) with an average time of eight months between the onset of symptoms and death. The average survival time after gastrostomy was five months. Therefore, the average survival time of the explored non-resectable group, with or without gastrostomy, was approximately the same as in those having no treatment and in those inoperable cases treated by gastrostomy alone.

All of the 30 cases treated by resection had thoracic lesions. Twenty-four of the resections were obviously palliative, since all tumor could not be removed. Six of the resections were considered to be possibly curative. Of the 6 cases having theoretically curative resection, 4 (66%) died as a result of the operation. Of the 24 cases having palliative resection, 13 (54%) died as a result of the operation. The results obtained in the surviving 13 cases are shown in Table IX. Nine cases had palliative resection and an esophago-gastrostomy performed at various levels in the thorax or neck. Eight of these cases have died. In these 8 cases, the average time between the onset of symptoms and death was 15 months, and between resection and death 7 months. However, these 8 patients had much improvement subjectively as a result of the restoration of the ability to swallow. The remaining case treated by palliative resection and esophagostomy is still

living and well 11 months after operation at the time of this report in spite of the presence of residual tumor in the mediastinum. One of the remaining 2 survivors of palliative resection had an esophago-esophageal end-to-end anastomosis.⁷ This case survived nine months after operation, with normal swallowing for the first four months of this time. The one case remaining among those treated by palliative resection had a Thorek operation, an operation now discarded because of its obvious disadvantages.

One of the two cases surviving theoretically curative resection (Table IX) lived for 13 months after the onset of symptoms and 12 months after operation. During the first seven months after operation, there was a return of the ability to swallow satisfactorily. The other case surviving a theoretically curative resection has remained well for 37 months following an operation at the time of this report. He has maintained his weight, his swallowing has remained normal and there has been no evidence of recurrent carcinoma.

Table X shows the types of resections and the levels of the intrathoracic anastomoses performed, with the mortality rates for each. The technique of the operations is described elsewhere.⁸ The average operative mortality rate for the 30 cases treated by resection was 57%.⁹

Table XI shows the causes of death in the cases treated by resection. It is apparent that empyema or mediastinitis from anastomotic leaks were the most frequent complication. One case had both a subarachnoid hemorrhage and an anastomotic leak with empyema accounting for the listing of 18 causes among 17 cases. The death due to incompatible blood was an error which occurred despite the usual precautions. The death due to cardiac arrhythmia occurred in a patient with no evidence of pre-existing cardiac disease.

DISCUSSION

There is no known explanation for the high incidence of carcinoma of the esophagus in this locality. It is interesting that 94% of these cases were so-called service or clinic patients, while only 6% were private patients. This combined with the fact that the majority were negroes does not allow any sound impression as to the relative importance of economic, environmental, occupational, racial or other unknown factors.

This review presents the grim fact that there are only 2 of 170 patients with carcinoma of the esophagus living today, among those seen from January 1941 through June 1951. In reflecting upon the problem of trying to obtain better results, there is probably no one answer. However, the failure to establish the diagnosis earlier in the course of the disease must be a major factor. This would not seem to apply to those 69 cases (40.7%) who had symptoms of two months

or lesser duration, and even less so to those 30 cases (17.7%) with symptoms of three weeks or lesser duration. However, it would seem to apply to those 101 cases (59.3%) who had symptoms for periods greater than two months. In any patient with any symptom, notably a sense of obstruction or pain on swallowing, conceivably due to carcinoma of the esophagus, two examinations are indicated immediately. One is the barium swallow and the other is esophagoscopy. While the barium swallow is generally used, unfortunately too often too late, to determine the presence or absence of a filling defect in the esophagus, it is not recognized generally that the endoscopic examination is indicated also even if the radiographic examination is normal. In our series of cases, there were at least 3 cases having a normal esophagus upon radiographic examination, who were found to have carcinoma upon esophagoscopy and biopsy. Granting that all carcinomata must be sufficiently small in their early course so as not to cause any great degree of obstruction, it is also reasonable to believe that at some time the size of a carcinoma could be so small that it would not be detectable upon radiographic examination, whereas it would be upon direct observation with a scope. This is believed to be true because the vast majority of carcinomata of the esophagus are epidermoid in type and therefore arise in the mucosal lining which is easily accessible to a scope.

It is believed that if it were possible to establish the diagnosis of carcinoma of the esophagus sooner after the onset of symptoms than it was possible to do in the majority of the cases in this series, the results would be distinctly better. One cannot be certain of the increase in the number of cures to be accomplished thereby, but surely the number of cases having successful and worthwhile palliation should be increased considerably.

Another problem pertaining to the question of obtaining better results in the treatment of carcinoma of the esophagus concerns the treatment of starvation, to which these patients are particularly subject. Probably secondary to starvation are the additional problems of reduced blood volume, the poor reparative powers of the tissues, and the decreased resistance to infection, blood loss, and stress. Unfortunately, it is extremely difficult and well nigh impossible to correct the severe malnutrition so often associated with carcinoma of the esophagus even in the absence of demonstrable metastases. Until it becomes possible to correct this malnutrition, the results of treatment of the carcinoma will probably still remain far below those to be desired.

Although there have been recently several reports^{9,10,11} on the efficacy of radiation therapy, it is believed that at present the treatment of choice for carcinoma of the esophagus is its complete surgical extirpation. This is combined with excision of a long segment of normal appearing esophagus above the

⁹It is gratifying to report that in the last 7 consecutive cases treated by resection, there have been only 2 post-operative deaths, a mortality rate of 28.5%.

upper gross extent of the tumor, and all of the esophagus distal to the tumor. Further it is combined with excision of all accessible and expendable regional sites of spread or possible spread. After the above, the stomach is substituted for the esophagus to re-establish the continuity of the intestinal tract by esophago-gastrostomy in the thorax, or in the neck with the stomach traversing the thorax. All of the above is accomplished in a single operation performed through the left side of the thorax, with access to the abdomen through the diaphragm, and with the addition of a cervical incision if indicated. The approach on the left is preferred at present, although combined abdominal and right thoracic approaches have some desirable features in selected cases. It is our belief that excision of the primary tumor and restoration of the ability to swallow is virtually always indicated, barring concomitant serious cardiac, renal or hepatic disease contraindicating operation, even if it is known preoperatively or if it is found at operation that the resection is to be palliative rather than theoretically curative, provided the malnutrition is not so advanced as to constitute a contraindication per se. In the inoperable cases, there has been no significant palliation accomplished by any method. In the operable and resectable though incurable cases, the palliation has been very significant and the patients have been most grateful. In adopting this view it is recognized that the hazard of operation is very great indeed, but also it is recalled that it has been said truthfully that life without the ability to swallow in the presence of carcinoma is only a life not worth living.

SUMMARY

- 1. A clinical evaluation of 170 cases of histologically proven esophageal carcinoma is presented. Eighty-six per cent of the cases were Negroes.
- 2. There is locally a relatively higher incidence of esophageal carcinoma than reported elsewhere in the United States. In this clinic, there is a higher incidence of carcinoma of the esophagus than of the stomach, rectum, or colon.
- 3. The majority of the lesions were in the middle one-half of the thoracic esophagus.
- 4. The duration of comfort and life in the inoperable and non-resectable cases was not increased appreciably by the use of gastrostomy, with or without roentgen therapy.
- 5. Only 33% of the 170 cases were operable and of these only 54% were resectable. The mortality rate for all cases treated by resection was 57%. Only 3% of all cases had theoretically curative resections.
- 6. The majority of the patients surviving resection had restoration of the ability to swallow for most of their remaining life, and lived twice as long after the onset of symptoms as those with no treatment or those with gastrostomy.

- 7. Only 2 of the 170 cases are still living.
- 8. The problems concerned with trying to obtain better results than those reported in this review, chiefly through earlier diagnosis and treatment, are discussed.

TABLE I

Relative Incidence of Carcinomata of Several Sites Among Hospital Patients—Service and Private—During the Eleven Year Period January, 1940—January, 1951

Site	Number of Cases
Esophagus	155
Stomach	146
Colon and Rectum	103
Breast (10 years only) ⁵	220

TABLE II

Ages	Number of Cases	Percent
20 - 29	2	1.2
30 - 39	17	10.0
40 - 49	44	26.0
50 - 59	52	30.8
60 - 69	44	26.0
70 - 79	10	6.0
Totals	169	100.0

Age of one patient not recorded

TABLE III

Sex and Race	Number of Cases	Percent
Colored males	82	49
Colored females	63	37
White males	14	8
White females	11	6
Colored	86%	Females 43%
White	14%	Males 57%

TABLE IV
SYMPTOMS

Dysphagia—first symptom—122 cases—70.5%
Pain in chest not necessarily only on swallowing
first symptom most commonly in remainder.

	Number of Cases	Percent
Dysphagia	158	91.3
Weight loss	148	85.5
Pain	62	36.4
Regurgitation	48	27.7
Cough	25	14.4
Hoarseness	18	10.4

Substernal fullness, nausea and vomiting, hematemesis, hemoptysis, fever, singulitus, sorethroat, dyspnoea and melana.

TABLE V
DURATION OF SYMPTOMS

	Number of Cases	Percent
Less than 3 weeks	30	17.7
3 weeks - 2 months	39	23.0
2 - 6 months	46	27.0
6 - 12 months	47	27.6
12 - 18 months	1	0.6
18 - 24 months	0	0.0
Over 24 months	2	1.1
Unknown	5	3.0
Total	170	100.0

Duration did not influence rate of operability.

TABLE VI
PHYSICAL EXAMINATION

Emaciation or cachexia	
Dehydration	
Anemia	
Marked dental caries	
Cervical lymphadenopathy	
Hoarseness	
Cough on observing the patient swallow	

TABLE VII
ASSOCIATED DISEASES

Heart Disease	22 Instances
Positive Wassermann	14 "
Other Malignant Tumors	6 "
Aortic Aneurysm	4 "
Pulmonary Tuberculosis	3 "
Diabetes	2 "
Renal Calculus	1 "
Carotid Aneurysm	1 "
Subacute Bacterial Endocarditis	1 "
Nodular Goiter	2 "
56 Instances (not cases)	

TABLE VIII
Treatment of Inoperable Cases
Average Survival Times in Months

	Cases Followed	Onset Symptoms To Death	Treat- ment To Death	Cases Living
No treatment	41	7.5	--	0
Gastrostomy alone	53	9.8	3.8	0
Gastrostomy plus x-ray	4	9.2	5.1	0
Gastrostomy plus other*	4	6.0	2.1	0
Jejunostomy alone	3	5.0	1.5	0
X-ray alone	3	11.0	3.0	0
Testosterone and dilations	1	5.0	1.0	0

*See text

TABLE X
Types of Resection and Anastomosis
For Thoracic Lesions

	Cases	Survived	Died	Mortality Rate
Thorek	4	1	3	75%
E-G° in neck	7	4	3	43%
E-G° above arch	7	2	5	70%
E-G° at arch	5	1	4	80%
E-G° below arch	6	4	2	33%
End-to-end (low)	1	1	0	0%
Totals	30	13	17	57%

*Esophago-gastrostomy

TABLE IX
Treatment by Exploration for Thoracic Lesions
Surviving Non-Resectable and Resectable Cases
Average Time Intervals in Months

	Cases Followed	Later Deaths	Onset To Death	Operation To Death	Improved	Cases Living
N-R thor. c (G)	17	17	8	5	0	0
N-R thor. s (G)	1	1	8	4	0	0
Res. thor. (E-G) p	9	8	15	7	5	1 (11 mos.)
Res. thor. (Tk) p	1	1	15	10	8(?)	0
Res. thor. (E-E) p	1	1	23	9	4	0
Res. thor. (E-G) c	2	1	13	12	7	1 (37 mos.)

N-R—non-resectable. Res.—resectable. Thor.—thoracic. G—gastrostomy. E-G—esophago-gastrostomy. Tk—Thorek. E-E—end-to-end anastomosis. p—palliative. c—curative.

TABLE XI
Causes of Death Following Operation

Anastomotic leak and empyema	7 cases
Empyema	4 cases
Hemorrhage and/or shock	3 cases
Mediastinitis	1 case
Subarachnoid hemorrhage	1 case
Cardiac arrhythmia	1 case
Incompatible blood	1 case

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THE PRESIDENT'S PAGE

It was with considerable regret that the President called a special meeting of the House of Delegates on December 9. The Council asked for the meeting in order that it might present to the House for action a proposed petition it had prepared, after much study and serious consideration. This proposed petition was directed to the South Carolina General Assembly, and it was requested that a law be enacted to reconstitute the State Board of Health and the Executive Committee of the State Board of Health. The proposals of Council had previously been sent to each delegate so that the House could assemble already well informed.

The attendance at the meeting was gratifying, over fifty delegates having taken their seats before the meeting was called to order.

Dr. O. B. Mayer stated the object of the meeting and he and other members of Council briefly stated the background of the situation and of the studies that had been made by Council, which led up to the proposal that had been made.

The House then sat as in committee of the whole, so that discussion could be conducted informally and fully. A group from the Charleston society, led by Dr. O. B. Chamberlain, presented an alternative petition, which while differing in several more or less minor details, still incorporated the main recommendations of Council. These recommendations were amended in several less important respects. Then the committee of the whole recommended that this alternative petition from the Charleston group, instead of that offered by Council, be recommended to the House for adoption. This recommendation of the committee of the whole was received by the House and was adopted as the action of that body, with little dissent.

Briefly, the petition to the General Assembly of South Carolina requests that the South Carolina Medical Association, in its corporate capacity, be no longer the State Board of Health, and that the Executive Committee of the State Board of Health be abolished. In their stead, it was requested that a new State Board of Health, composed of nine members with staggered terms of office, and composed of three doctors of medicine, one dentist, one graduate registered nurse, one pharmacist and three citizens of the state not engaged in health service be established. It was pro-

posed that the medical members (doctors, dentist, nurse and pharmacist) be nominated for appointment by the governor by their respective state organizations and that they and the other members be appointed by the governor for terms of four years, except for shorter terms at first, so as to bring about a staggering of expirations of terms of appointment. This newly constituted State Board of Health would assume all the duties of the present Board of Health (The South Carolina Medical Association) and of the present Executive Committee of the State Board of Health, including the selection and employment of a State Health Officer.

There would also be created a State Department of Health, to be headed by the State Health Officer, which would be the executive body charged with carrying out the policies and enforcing the health regulations of the State Board of Health and laws pertaining to public health.

A special committee, headed by the President, was provided for, to present this petition of the House of Delegates to the General Assembly and to seek the adoption of a bill incorporating the requests contained in the petition. When this is published, that committee will have already taken steps to carry out that mandate.

A second matter for consideration was included in the call for the special meeting of the House of Delegates. This was the proposal to hold this next year a recessed meeting of the House of Delegates, that all recommendations, new resolutions and other important matters requiring action by the House should be referred to reference committees for hearings, such hearings to be held during the recess on the afternoon and evening of the first day of the annual meeting, and then be reported back to the House the next morning at the recessed meeting, and that the annual banquet be held on Thursday night rather than Wednesday, so making of it the closing event of the meeting. This proposal would necessitate the scientific program's beginning Wednesday afternoon and continuing through Thursday afternoon.

This proposal was presented to the House for action and was unanimously adopted without adverse discussion.

J. Decherd Guess

The Journal of the South Carolina Medical Association

EDITOR: Julian P. Price

Florence, S. C.

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FEBRUARY, 1952

ANNUAL MEETING

Under the new plan proposed by our President, Dr. J. D. Guess, and endorsed by Council, the annual meeting will be held as follows:

Tuesday afternoon, May 13, House of Delegates

Tuesday evening, May 13, Reference Committees

Wednesday morning, May 14, House of Delegates

Wednesday afternoon, May 14, Scientific session

Thursday morning, May 15, Scientific session

Thursday afternoon, May 15, Scientific session

Thursday evening, May 15, Annual banquet

Headquarters will be the Ocean Forest Hotel,
Myrtle Beach, S. C.

BIG FIVE

These five might be termed the key men in the American Medical Association; Dr. John Cline, President, Dr. Louis Bauer, President-Elect, Dr. Dwight Murray, Chairman of the Board of Trustees, Dr. George Lull, Secretary and General Manager, and Dr. Austin Smith, Editor of the Journal.

Three of these, Drs. Cline, Lull, and Smith, have been guests in our state during recent years, and last month Dr. Bauer paid an official visit. That leaves Dr. Murray, and although he lives in California and his activities do not bring him to the southland, we hope that the day is not far distant when he will afford us the opportunity of giving him a taste of South Carolina hospitality.

CONGRATULATIONS, COLUMBIA

The custom established by Dr. William Weston of having the President-Elect of the American Medical Association as the guest speaker at the January meeting of the Columbia Medical Society is one which should be appreciated by every member of our Association. The Columbia society is ever gracious with its invitations and the occasion affords a contact with our parent organization, the American Medical Association, which would be missed otherwise. Congratulations, Dr. Weston and the Columbia Society.

LOUIS H. BAUER

Few men have given more of their time and energy to American and World medicine than has Dr. Louis Bauer. After establishing himself as a medical leader in the state of New York, he began his work with the American Medical Association where his abilities were soon recognized and he was rapidly pushed up the ladder—member of the House of Delegates, member of the Board of Trustees, chairman of the Board of Trustees, and now President-Elect of the Association. One of the group responsible for the creation of the World Medical Association, he now serves as secretary of that organization.

In his informative and stimulating address on "Medicine and the Future," presented in Columbia recently, Dr. Bauer showed the extent of his knowledge and the breadth of his vision. We do not believe we could have found a better man to fill the office which he now holds.

COMING ELECTIONS

County medical societies are now electing their officers for the year and it will not be long before the state association will be choosing its leaders for the days ahead. This Journal plays no favorites and endorses no candidates, but merely begs that these new officers and leaders be selected with care. The future is uncertain and positive leadership is imperative.

DUES PAYABLE

Dues are now payable;

County dues—(see county treasurer)

S. C. Med. Association ----- \$20.00

A.M.A. ----- \$25.00

SOUTH CAROLINIANA

J. I. WARING, M.D., CHARLESTON, S. C.

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CORRESPONDENCE

(Extract from a letter from Dr. J. W. Jervey, Greenville).

"Personally, I see no objection to moral grievance committees, and a state one too if you like. No physician who is doing what he should do need have any fear of such an arrangement, and the remainder (let us hope it is infinitesimal) should be frightened if we can do no better. Nor do I particularly care as to who makes up such committees so long as the doctors are freely represented and there is assurance that the personnel will be decent people.

"I seem to be in the minority on the matter of discontinuing the life membership in the house of delegates of our past presidents. I am attached to the present for by reason of sentiment to some extent. However, from a practical point of view I do not believe these men constitute any organized powerful minority group. They probably differ from one another as much as you and I would. Furthermore, there are the persons of our own free choice as a rule and should be continually looked to for help and guidance so long as it is available. They can never be a large number and what influence they do have will necessarily shrink with time as our state society enlarges.

Dr. Julian P. Price, Editor
South Carolina Medical Journal
Florence, South Carolina
Dear Dr. Price:

Kindly request that this letter be published in the South Carolina Medical Journal so that the informa-

tion contained in the following telegram received from the Chief Medical Director, Veterans Administration, Central Office, Washington, D. C., on December 17, 1951, can be disseminated to all members of the South Carolina Medical Association who are participating in the outpatient treatment of eligible veterans.

"Information this office indicates that some fee basis physicians are prescribing alcoholic beverages in connection with authorized outpatient treatment veteran patients. Existing VA regulations prohibit prescribing alcoholic beverages for outpatients and this restriction extends to prescribing by fee basis and designated physicians. With other suitable recognized therapeutic agents available, whiskey and other alcoholic beverages are not considered appropriate for prescription order for outpatient use. Please instruct all fee basis physicians and concerned medical societies or intermediaries accordingly. Pharmaceutical associations being advised not to accept prescriptions for alcoholic beverages after January 15, 1952. Prescriptions accepted in good faith and filled prior to that date may be processed for payment if otherwise in order."

Your cooperation in this matter is deeply appreciated.

With kindest regards, I am

Cordially yours,
JOHN B. COUSAR, M. D.
Chief Medical Officer

THE TEN POINT PROGRAM

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

BAUER TELLS MEDICAL MEN OF PROGRESS

("The State" Columbia, January 15, 1952).

"There is no reason to believe that any disease exists for which prevention and cure will not be found eventually," members of the Columbia Medical society were told at their monthly meeting at the Hotel Columbia last night.

Dr. Louis H. Bauer, president-elect of the American Medical society, in an address before the group noted the progress made in medical science in the past 25 years. The trends in the socio-economic field, however, Doctor Bauer called "not only disheartening, but downright alarming."

"The average life span has increased 20 years in the last 50 years and will probably continue to increase," Doctor Bauer said.

"Medicine is no longer solely a matter for the medical profession," he said. "The public needs education on the dangers of certain diseases and how to prevent them; the necessity of early immunization; the dangers of self-medication, charlatanism and quackery. It should be informed of the resources of medicine and the necessity for the protection of medical research," he added.

Doctor Bauer called for a continuance of the medical profession's fight against socialized medicine.

"Many seem to feel that we have won our fight against socialized medicine. I assure you we have not. We have won a breathing space," Doctor Bauer said. The socializers are for the moment not trying to move socialized medicine through the 'front door,' he added. "but they are still trying to 'inch it in by degrees' through the 'back door.'"

He called for further expansion of voluntary health insurance; adequate medical care for the indigent; adequate hospital facilities; further protection against financially catastrophic illness, all led by the medical profession, as a buffer to socialization.

"We must realize that we cannot practice medicine as we did 25 years ago," he told the medical group.

SOCIALIZATION IN ANY FORM RAKED*

The South Carolina Medical Society is sponsoring a contest for high school students, to write essays on the private medical programs in the country. Probably the background for the contest is the continuing efforts of government toward a semi-socialization of medicine, which hasn't worked out in England and could not in this country.

Similarly, the government in certain cases and instances is pushing its compulsory health insurance plans wherever and whenever the opportunity arises.

The voluntary medical insurance systems, which provide protection for the family at a cost of a few dollars a month, have been an outstanding success. Their membership runs into the tens of millions and is growing still. But the proponents of compulsory government health insurance, which is a polite term for semi-socialized medicine, have criticized them on the grounds that they do not cover catastrophic illness—that is, chronic ailments of long duration.

Yet the fact is that the proposed government insurance system does not meet this problem. It provides only for a brief and limited period of hospitalization and other services. It would offer nothing that private plans do not offer. But it would substitute compulsion for voluntary action by the individual, and it would saddle the medical fraternity and the taxpayers of the nation with a great new bureaucracy with an annual budget of many billions.

Moreover, much work is now being done by the medical men and the voluntary insurance organizations in attacking the problem of catastrophic illness.

American health standards are now the best in the world. That is an accomplishment of free medicine and voluntary action by the people. Still better standards will result from the same causes.

While The News realizes that in the field of medical insurance and in the fields of medical practice there are certain unscrupulous characters who make the public pay more through the nose than is justified, it feels by and large the medical doctors of our nation, our state and particularly Lancaster county and area, are honest, forthright and hard working men, who have the welfare of the people they serve at heart.

We state that we are backing the medical profession as a private profession and reject any attempts to socialize in any form. If a foothold were gained there, who can say it might not be gained in the newspaper business, or any business with which we in Lancaster are concerned.

STATEMENT BY THE PRESIDENT (CREATING THE "PRESIDENT'S COMMISSION ON THE HEALTH NEEDS OF THE NATION")

I have today signed an Executive Order creating the President's Commission on the Health Needs of the Nation.

The Commission has one major objective. During this crucial period in our country's history it will make a critical study of our total health requirements, both immediate and long-term, and will recommend courses of action to meet these needs.

I have long been interested in safeguarding and

*Reprinted from Lancaster News, January 11, 1952.

improving the health of our people. The provision of adequate health care for all of our population must be a matter of national, as well as local, concern. It is particularly important that in this day of world crisis we should seek to limit the drain upon our strength through illness and death.

We have made progress in our attack upon health problems through such measures as aid for hospital construction, medical research, and maternal, child health and crippled children's services. And we are making every effort for the most effective utilization of available health resources during this emergency. The Health Resources Advisory Committee in the Office of Defense Mobilization, the Inter-Agency Health Council, and the Armed Forces Medical Policy Council, in cooperation with other Federal, State, and local agencies and our civilian health professions, are doing a good job in coordinating programs so that mobilization needs may be met without endangering the health services which are vital to our civilian population.

We still have a long way to go, however, before we can hope to provide for the health needs of our people on both an immediate and long-time basis. Many vital problems remain unanswered, such as insuring an adequate supply of physicians, dentists, nurses and allied personnel; developing local public units throughout the Nation; making more hospitals and hospital beds available where needed; stepping up the tempo of fundamental medical research; meeting the needs of the chronically ill and aged; and providing adequate diagnostic, rehabilitative, and other health services to all income groups.

I have repeatedly endorsed programs to solve these problems. Our attempts to take constructive action on these issues have met enthusiastic support from some quarters and bitter opposition from others. As a result, our people are confused about the proper course of action on subjects so vitally important to their welfare. On a number of occasions I have stated that I would be happy to consider suggestions which were better than the measures I have endorsed to bring the continuing achievements of medical progress to all our people. But such counter-proposals have not been forthcoming.

I have, therefore, established the President's Commission on the Health Needs of the Nation to study the facts and to present its recommendations for safeguarding and improving the health of the Nation. Since we need the advice of all viewpoints, the Commission contains both professional and lay members. It will make a searching inquiry into the facts and give us the benefit of objective and constructive thinking on these problems which are of vital concern to every American.

The Commission is authorized to present interim reports on its findings, so that we shall have the benefit of its timely studies within the next twelve months. To aid in its deliberations within this period, the Commission will have available a number of studies in the

health field of governmental agencies, Congressional committees, and other public and private groups. Moreover, I have asked the Commission to give its immediate attention to an evaluation of the most recent information on subjects currently pending before the Congress and requiring consideration in the next session, such as aid to medical education and aid to local public health units.

We must dedicate ourselves to the continuing search for what is best for the nation in solving our health problems. I am certain that the President's Commission on the Health Needs of the Nation will make an invaluable contribution toward preserving one of our most precious assets, the health of all of our people.

EXECUTIVE ORDER ESTABLISHING THE PRESIDENT'S COMMISSION ON THE HEALTH NEEDS OF THE NATION

WHEREAS our Nation's strength is directly dependent upon the health of its people; and

WHEREAS the needs of our military, defense-production, and civil-defense programs for an assured and adequate supply of personnel and services present special problems in the allocation of our health resources during this emergency period; and

WHEREAS it is essential that at all times adequate provision be made to meet the health needs of the general public, including veterans; and

WHEREAS an objective appraisal of the effect of actions taken to provide for immediate and emergency needs is essential at this time in order that we may continue to meet long-term requirements for safeguarding and improving the health of the Nation:

NOW, THEREFORE, by virtue of the authority vested in me as President of the United States, it is ordered as follows:

Section 1. There is hereby established a commission to be known as the President's Commission on the Health Needs of the Nation, which shall consist of a chairman and fourteen other members to be designated by the President.

Section 2. The Commission is authorized and directed to inquire into and study the following:

(a) The current and prospective supply of physicians, dentists, nurses, hospital administrators, and allied professional workers; the adequacy of this supply in terms of the present demands for service; and the ability of educational institutions and other training facilities to provide such additional trained persons as may be required to meet prospective requirements.

(b) The present ability of local public health units to meet demands imposed by civil-defense requirements and by the needs of the general public during this mobilization period.

(c) The problems created by the shift of thousands of workers to defense-production areas requiring the relocation of doctors and other professional personnel



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Through its anticholinergic effects, Banthine inhibits excess vagal stimulation and controls hypermotility.

In Peptic Ulcer—the value of the oral form of Banthine is now well established. However, edema in the ulcer area may indicate parenteral Banthine until the healing processes have reduced the edema.

In Pancreatitis—it has been found that parenteral Banthine relieves pain, effects a fall in blood amylase and produces a general improvement in the patient's condition.

In Visceral Spasm—it inhibits motility of the gastrointestinal and urinary tracts.

Parenteral BANTHINE is supplied in serum-type ampuls containing 50 mg. of Banthine powder. Adult dosage is generally the same as with Banthine tablets.



RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

and the establishment of additional facilities to meet health needs.

(d) The degree to which existing and planned medical facilities such as hospitals and clinics, meet present and prospective needs for such facilities.

(e) Current research activities in the field of health and the programs needed to keep pace with new developments.

(f) The effect upon the continued maintenance of a desirable standard of civilian health of the actions taken to meet the long-range requirements of military, civil-defense, veteran's, and other public-service programs for medical personnel and facilities.

(g) The adequacy of private and public programs designed to provide methods of financing medical care.

(h) The extent of Federal, State, and local-government services in the health field, and the desirable level of expenditures for such purposes taking into consideration other financial obligations of government and the expenditures for health purposes from private sources.

Section 3. The Commission shall present to the President in writing such interim reports and final report of its studies of the subjects designated in Section 2 of this order, including its recommendations for governmental action, either legislative or administrative, as it shall deem appropriate.

Section 4. In connection with its inquiries and studies, the Commission is authorized to hold such public hearings and to hear such witnesses as it may deem appropriate.

Section 5. All executive departments and agencies of the Federal Government are authorized and directed to cooperate with the Commission in its work and to furnish the Commission such information and assistance, not inconsistent with law, as it may require in the performance of its functions and duties; but this order shall not be construed as otherwise modifying the functions or responsibilities of any such department or agency.

Section 6. The expenditures of the Commission shall be paid out of an allotment made by the President from the appropriation entitled "Emergency Fund for the President, National Defense" (Title III of the Independent Offices Appropriation Act, 1952, Public Law 137, 82nd Congress, approved August 31, 1951). Such payments shall be made without regard to the provisions of (a) section 3681 of the Revised Statutes of the United States (31 U.S.C. 672), (b) section 9 of the act of March 4, 1909, 35 Stat. 1027 (31 U.S.C. 673), and (c) such other laws as the President may hereafter specify.

Section 7. The Commission shall cease to exist thirty days after rendition of its final report to the President under section 3 of this order, or one year after the date of this order, whichever shall first occur.

HARRY S. TRUMAN

THE WHITE HOUSE,

December 29, 1951

HELPING NEGRO PHYSICIANS*

The chartering of a new Charleston County Medical Society will serve to separate the purely professional functions of a county medical society from the administering of large investments by the South Carolina Medical Society. The separation was designed primarily to safeguard these investments, principally the ownership of Roper Hospital, but it may have another important and progressive function, improvement of the professional status of Negro physicians.

To achieve recognition of the American Medical Association, an important item because it involves admission to practice in certain hospitals and attendance at scientific discussions, a doctor first must be a member of his county and State medical associations.

The South Carolina Medical Association, a State organization not to be confused with the venerable South Carolina Medical Society, is giving consideration now to admitting colored doctors. A study committee is scheduled to report on the subject next May. If the State association decides to admit colored doctors, by that time the new Charleston County Medical Society would be in a position to take similar action and clear the way toward membership of local Negro doctors in the AMA.

The South Carolina Medical Society, one of the oldest medical groups in the United States, in reality now is the county medical society for Charleston County. It also is trustee for large sums of money, many of them bequests. Furthermore, it is a social organization for white physicians. Thus by separation from State and national bodies, just announced, its trusteeship and social functions remain under control of the white doctors while the way would be open to admit qualified Negro doctors to the new county society for professional purposes.

Here is a practical illustration of maintaining separation of the races without interfering with smooth business and professional relations. If these things come about, they should prove satisfactory to both races. The colored people of the community would gain by having physicians of their race given full local professional standing.

By such amicable adjustments many of the racial problems in the South can be settled. The News and Courier favors exploring every opportunity for such improvements.

\$18 BILLION U. S. COST SEEN IN HEALTH INSURANCE PLAN

Adoption by the United States of an all-inclusive national medical service like that in Britain would cost the federal government at least \$18 billion a year, perhaps more according to Miss Elizabeth W. Wilson, actuary and economist who has specialized in government health insurance. Americans now spend approximately \$10 billion yearly on both private and government medical care, she reports.

*Reprinted from the News and Courier, December 29, 1951.

Recalling that the British health service is presently costing approximately three times the amount originally named by advocates, Miss Wilson points out that the cost of any such system rises with the rise of salaries and the cost of materials. Inflation has boosted the cost of the British health service, and would boost the comparably sized American health service in the same way. In fact, the present estimate of \$18 billion more than a similar estimate made three years ago, she said. That means a 20 per cent increase.

The introduction of socialized medicine would be inflationary in itself in tendency, Miss Wilson reasons, because \$18 billion more than is being spent in the United States for medical care at the present time. Unless such an added expenditure would result in the production of \$8 billion more goods, the net result would be inflationary, she warns.

Miss Wilson, who has studied Britain's experiment in socialized medicine firsthand, traveling up and down Britain for several months, observes that advocates of compulsory health insurance argue that state medicine cuts industrial absenteeism—that it means fewer worker absences from the factories and mines, and hence results in a larger national product.

The opposite has happened in countries with such a system, she reports. In Britain, the increase in "days lost" by the coal miners since 1948 has posed serious problems for the National Coal Board. In Germany, the average absence from work has more than doubled in the 45 years following introduction of a compulsory health system.

No one would contend that the introduction of socialized medicine has been the main cause of the increased absenteeism, Miss Wilson states. But it obviously does not prevent such absenteeism, and there is no evidence yet that it has increased the national product appreciably.

The figure of \$18,000,000,000 represents about 7.5 per cent of the total annual income, Miss Wilson reports, whereas today the average American worker pays only about 4 per cent of his wages to medical care. She asks whether the average workman—if he knew the actual figures—would wish to nearly double his expenditures to obtain the benefits of government medicine. (The Christian Science Monitor, Dec. 10, 1951)

SOMETHING CAN BE DONE ABOUT CHRONIC ILLNESS

A brightening picture for chronic illness is described in the recently released pamphlet "Something Can Be Done About Chronic Illness."

The pamphlet was prepared and published by the Public Affairs Committee in cooperation with the Commission on Chronic Illness. Summarizing the current situation regarding chronic illness in the U. S., the pamphlet states.

"Within the last generation medical science has advanced further against chronic disease than ever before. It has given us insulin for diabetes, sodium dilantin for epilepsy, cortisone and ACTH for rheumatoid arthritis and has developed safer and surer diagnostic methods . . .

"For many persons chronic has taken on connotations of helplessness and hopelessness. Doctors, nurses, social workers, patients—all of us—would be more likely to combat chronic disease intelligently if we viewed the word only in its literal meaning. Chronic comes from the Greek Chronikos, 'concerning Time.' A chronic disease is one that lasts a long time."

The pamphlet discusses prevention of chronic disease, the pros and cons of multiple screening, the problems of long term hospital and home care and proposes rehabilitation programs geared to the needs of rural areas, small communities and large cities. "Rehabilitation's worth" is cited. The average cost of rehabilitating a group of 60,000 people in 1950 was \$492, "about what it costs to keep one person on relief for one year. The cost of dependency, of course, goes on year after year; the cost of rehabilitation must be met just once."

The concluding check-list for the interested citizens suggests directions for community action on the problem.

A complimentary copy for News Letter readers has been mailed with this issue. Additional copies can be obtained at 25 cents each or at bulk rates for larger quantities from the Public Affairs Committee, Inc., 22 East 38th Street, New York 16, New York.

(Chronic Illness News Letter)

January 1952

URGES SHIFT IN OLD AGE ASSISTANCE PLANNING

The general budget would be relieved of an annual burden of \$800 to \$900 million if the Federal government's share of current Old Age Assistance was placed under the Old Age and Survivors' Insurance Program, according to H. Albert Linton, president of the Provident Mutual Life Insurance Co. and president of the Life Insurance Association of America.

Mr. Linton yesterday told the closing session of the Association's 45th annual meeting here that "such a move would probably reduce political pressures. We of this generation would understand more fully the true costs of pensions. If benefit levels were to be raised for those currently on the rolls, money would have to be found immediately to pay the increased costs. We would, therefore, be less likely to promise unduly high benefits for others to pay in the future. There would be no temporary excess of income over outgo in the O. A. S. I. system as at present to make it appear feasible to set benefits at unsound levels which could impose a future dangerous burden upon the economy of the country."

Sounds Warning: Mr. Linton sounded a warning on keeping social insurance in its proper role. He stressed that it should be a system providing benefits on a level which will always leave ample opportunity and incentive for the individual to supplement them by his own efforts.

"The country would be in grave danger the moment social insurance benefits should reach levels that would kill the incentives to work and strive for something better," he declared. "Moreover, the effects of such a situation on the individual character and, in turn upon the national character, would be disastrous. In the world struggle for survival the emphasis must be on self-reliance and character that seeks to make its way through productive work and enterprise. Furthermore, if we should ever arrive at the position where the great mass of people would look at the Federal Government for complete security against the hazards of life we would be well on our way to dictatorship."

Steps must be taken to see that more people over 65 are employed in productive work if the standards of living of the American people are to be kept at a high level, Mr. Linton said.

Non-workers Increasing: Mr. Linton pointed out

that the decreasing dependency ratio—the relationship of the number of non-working persons to those of all ages who are working—which contributed to the increasing prosperity in this country for the last half century or more, seems destined to be replaced by a rising one. "The economic significance of this change," he declared "is something to be considered with great care."

Explaining that only about 43 per cent of men aged 65 or over are now gainfully employed, as compared with 68 per cent 60 years ago, Mr. Linton said it would be well "to attempt to find out why the proportion has decreased and whether there is any way by which it can be raised to former levels."

He admitted that the achievement of the goal of productive activity for persons desiring to work in the later years of life "is easier said than done," and pointed to many conferences held along this line by social workers, employers, employes, medical men and others interested in the problems of aging. He suggested that "perhaps a qualified non-political commission set up by Congress could help in pointing the way toward a constructive program and bringing it forcibly to the attention of the country." (Journal of Commerce, Dec. 13, 1951)

Refresh...add zest
to the hour



WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. K. D. Shealy, Columbia, S. C.

Publicity Secretary: Mrs. Weston Cook, Columbia, S. C.

Mrs. J. W. Kitchens of Liberty, has accepted the office of first-vice-president of the Woman's Auxiliary to the South Carolina Medical Association to replace Mrs. Clay Evatt of Charleston, who recently resigned, according to an announcement made by our State President, Mrs. Kirby D. Shealy.

MEDICAL ASSOCIATION ESSAY CONTEST

All medical auxiliary units in the state have been contacted by the state president, Mrs. Kirby D. Shealy, urging them to give active and immediate support to the Essay Contest being sponsored by the State Medical Association. Informative material has already been mailed to the junior and senior high schools throughout the state from the State Medical Association office in Florence.

This contest will be part of, and coordinated with the contest sponsored on a national scale by the Association of American Physicians and Surgeons, depending upon the co-operation of state and county medical societies. The subject: "Why the Private Practice of Medicine Furnishes this Country With the Finest Medical Care."

The members of the Woman's Auxiliary are asked to help in publicizing the contest and to stimulate interest among the students in the schools through the State. Success of the contest as an important educa-

tional feature in the current thought training of young America, depends upon the creation of widespread interest in the subject, and the fullest participation possible by High School students.

The film, "You Can Beat the A-Bomb," was shown to the members of the Woman's Auxiliary to the Columbia Medical Society at the Woman's Club House. The film ran for approximately twenty minutes and was of extreme interest to all those who saw it as an educational movie on how the civilian population can protect itself, lessen the loss of life, and prevent serious injury by preparing us to intelligently avoid coming in contact with radio active substances and flying missiles in event that we should be attacked by means of atomic bombs.

By using typical scenes and situations of persons living in cities, the film, "You Can Beat the A-Bomb," demonstrated methods of self protection against atomic bombing. Persons who are indoors or in the open can protect themselves not only from a direct injury by dispersion of atomic material in the air following atomic air bursts, but also it demonstrated how persons can reduce a likelihood of indirect injury as a result of flying objects such as glass, stone and other building materials. It gave directions also to avoid consumption of contaminated food and drink after it has been exposed to atomic explosion.

NEWS ITEMS

Dr. W. A. Boyd of Columbia was recently elected an honorary member of the North Carolina Orthopedic Association.

Dr. Sam C. Rankin, who has been practicing in Clinton for the past year, has recently moved to Bamberg where he will practice general medicine and surgery.

Dr. Hoke Wommack, Director of the cancer teaching program at the Medical College of Georgia, spoke to the Third District Medical Society at the January meeting in Greenwood. Dr. George V. Rosenberg of Abbeville, vice president of the society, presided over the meeting and introduced the speaker.

Dr. Archie C. Magee has recently opened offices in Cheraw for the practice of medicine.

Dr. James C. Shecut of Orangeburg, is the new chief of staff of the Orangeburg Regional Hospital.

Dr. H. W. Koopman of Spartanburg, was named "County Doctor of the Year" at the annual ladies' night banquet of the Spartanburg County Medical Society.

Dr. Norris Knoy has been appointed chief surgeon of the new Marion County Memorial Hospital.

Drs. J. L. and T. P. Vallev (father and son) of Pickens have moved into their new office building.

COUNTY MEDICAL SOCIETY OFFICERS ELECTED RECENTLY

Chester County Medical Society

President: Dr. J. N. Gaston, Jr.

Vice president: Dr. Charles W. Brice, Jr.

Sec.-Treas.:

Chesterfield County Medical Society

President: Dr. J. B. Perry

Vice president: Dr. J. E. Hodge

Sec.-Treas.: Dr. J. P. Harrison

Columbia Medical Society

President: Dr. W. P. Beckman

Vice president: Dr. Henry F. Hall

Secretary: Dr. Wm. S. Hall

Treasurer: Dr. E. W. Masters

Pickens County Medical Society

President: Dr. Charles E. Ballard

Vice president: Dr. J. H. Jameson

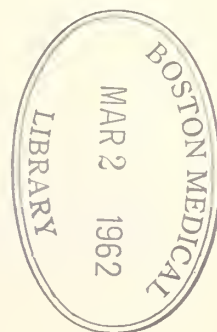
Sec.-Treas.: Dr. J. A. White

Union County Medical Society

President: Dr. F. P. Salley

Vice president: Dr. F. P. Owings

Sec.-Treas.: Dr. P. K. Switzer



Dr. James C. Brabham, former director of the Spartanburg County Health Department, is now practicing medicine in Pacolet.

The Georgia Society of Ophthalmology and Otolaryngology holds its annual meeting Friday and Saturday, March 7 and 8, 1952, at the well known resort hotel, The General Oglethorpe, Wilmington Island, Savannah, Georgia.

Registration fee is \$20.00.

The following men will speak:

DR. MURRAY F. McCASLIN, Pittsburgh
DR. J. CONRAD GEMEROY, Detroit
DR. JOSEPH S. HAAS, Chicago
DR. HENRY B. ORTON, Newark
DR. ALBERT P. SELTZER, Philadelphia
DR. JOHN R. LINDSAY, Chicago

ANNOUNCEMENT
Cancer Cytology Center—Dade County Cancer Institute
1155 North West 14th Street
Miami, Florida

The Division of Training of the Cancer Cytology Center of the Dade County Cancer Institute, an affiliate of the Medical Research Foundation of Dade County in Miami, Florida announces its second one-week seminar for physicians to be held at the Institute from April 21st--25th inclusive and im-

mediately preceding the annual convention of the Florida Medical Association.

The Seminar on Cancer Cytology will also include a conference on Carcinoma In-Situ.

Instruction will be under the supervision of Doctor J. Ernest Ayre, Director of the Institute and its research staff. More than twenty outstanding local and visiting physicians and scientists will compose the faculty.

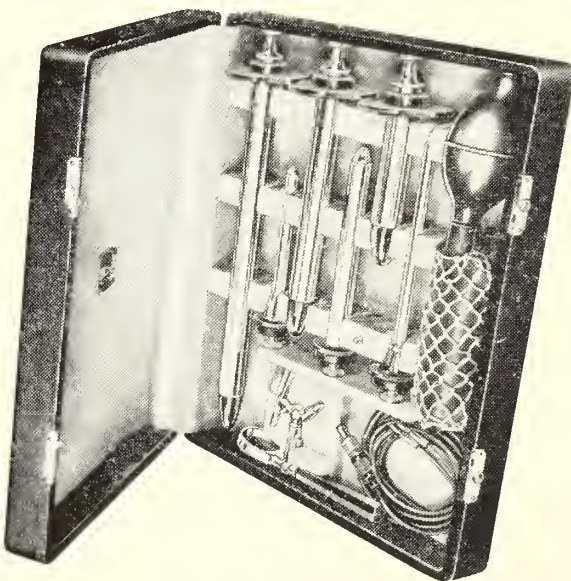
This first School of Cytology in Florida anticipates enrollment from local, State and regional areas as well as from the Caribbean.

The general course of instruction in cancer diagnosis and cytology will include lectures, demonstrations and symposia covering the various branches of medicine as related to cancer, including clinical, cytological, surgical and histopathological fields.

Interested physicians should direct their inquiries regarding qualifications, registration, fees and other details to the Director of the Dade County Cancer Institute at 1155 North West 14th Street, Miami, Florida.

Applications for registration, limited to 35 physicians, will be accepted through April 19th.

The Southeastern Allergy Association will hold its Seventh Annual Meeting at the Bon Air Hotel, Augusta, Ga. on March 21, and 22, 1952.



P and S Set No. 370

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**TEN POINT PROGRAM
OF THE
SOUTH CAROLINA MEDICAL ASSOCIATION**

1. Cooperation

To promote closer cooperation and better understanding between all agencies, groups and individuals concerned with providing and improving medical care for the people of South Carolina.

2. Extension of Medical Care

To study constantly the need and availability of medical care in each county of the State and in the State at large.

To promote plans for providing or improving medical care where there is a need, particularly in the rural areas.

3. Pre-Paid Hospital and Medical Care

To make voluntary pre-paid hospital and sickness insurance available to all the people of the State (through Blue Cross, Blue Shield, and commercial insurance policies), and to promote the widespread purchase of such insurance.

4. Care of Indigent

To work with local county and state agencies, and with philanthropic organizations, toward securing good medical care for the indigent.

5. Public Health

To support the South Carolina State Board of Health in its broad program of preventing diseases and of safeguarding the health of our people.

6. Health Councils

To support the State Health Council in its announced program. To sponsor

the formation of a County Health Council in every county of the state, and to encourage our members to support and to work with these organizations.

7. Hospitals

To promote the expansion of present hospital facilities and the building of new hospitals—where there is a definite need.

To strive for highest standards of professional care in the hospitals in the State.

8. Medical Colleges

To support the Medical College of the State of South Carolina and to bend our efforts toward keeping its standards of education on a par with other medical colleges throughout the country.

To promote good nursing education and good nursing care throughout the State.

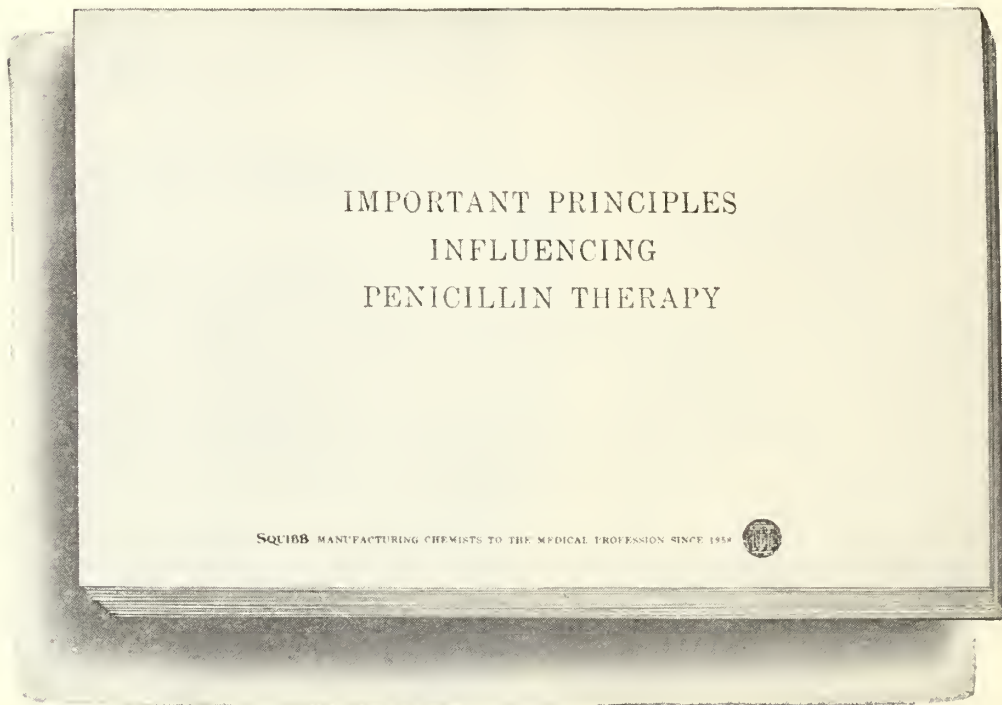
9. Education of the Public

To acquaint the citizens of the State with regard to the problems of medical care in existence today, to inform them as to what is being done to solve these problems, and to advise with them as to further plans for securing better health and better medical care for the people of South Carolina.

10. Political Medicine

To prevent political control or domination of medical practice or of medical education.

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VOLUME XLVIII

March, 1952

NUMBER 3

Tetanus Neonatorum—Report of A Case Treated With Mephenesin

RICHARD J. KAHALY, M. D.

JOHN R. HARVIN, M. D.

Columbia, S. C.

Among the problems encountered in the treatment of tetanus, one of the most serious is the relief of trismus and generalized rigidity. We feel that the drug Mephenesin (Tolserol) is of great value in the treatment of this spasm, and with its use, the care of these patients becomes much less of a therapeutic problem.

CASE REPORT

R. S. was delivered on October 28, 1950, in a private clinic by his family physician following a four-hour labor. There were no complications of labor, and the infant was discharged on the third post-partum day in good condition. The first week of life was uneventful, however, on the seventh day the father noted that the child was "somewhat stiff."

The family history revealed that the only other child of these parents, a male infant, was found dead in bed, of no apparent cause, at the age of three months. No autopsy was obtained and the etiology remained undetermined. The family is of moderate circumstances and live on a farm. The patient was cared for by his mother, who redressed the umbilicus daily. No history of tetanus could be obtained as having occurred in the immediate vicinity of the home.

On admission to the hospital, physical examination revealed a well developed and nourished one-week old white male infant in moderate distress. The skin was warm and dry with a fine maculopapular branny rash over the entire back, arms, shoulders, buttocks and thighs. There were no glands palpable and the skeletal system was of normal conformity. The head was symmetrical and the anterior fontanelle was open, but not bulging. The eyes reacted to light and the fundi were normal. The mucous membranes, nose and ears were normal. There was a three plus trismus present and the pharynx could not be visualized. The mouth could not be opened more than 0.5 cm. The neck and spine were moderately rigid. The chest expansion was equal and the lungs clear to percussion and auscultation. The heart was not enlarged to percussion; the rate normal and the rhythm regular with

no murmur present. There was no abdominal tenderness or palpable organs. The umbilical cord was off and the umbilicus was slightly red, but there was no exudate or serous material present. The genitalia were normal with moderate phimosis, and the extremities were of normal conformity. The arms and legs were held with moderate rigidity with the fingers clenched over the thumbs. Abdominal and cremasteric reflexes could not be obtained, the patellar reflexes were hyperactive, and the Babinski sign was negative. However, the examination of reflexes was not completely satisfactory because of the generalized rigidity which was present.

On admission the temperature was 99.4° F. A smear from the umbilicus was negative, but a gram positive staphylococcus was found on culture. No tetanus organism was found. The R.B.C. was 4,000,000; hemoglobin 80%; W.B.C. 16,200; polymorphonuclears 58%; lymphocytes 42%. Blood calcium was 11 mgs. percent, and the urine examination negative. Blood serology was negative. A spinal tap was done with difficulty due to the rigidity. The spinal fluid obtained was slightly blood-tinged with 10 to 15 red cells and an occasional white cell present; protein 20 mgs. percent; a trace of sugar and negative culture.

On admission, the child was placed on 30,000 units of penicillin every three hours, 12 drops of phenobarbital every four hours, 50 mgs. of streptomycin every six hours and ¼% neosynephrine nose drops.

In making the diagnosis, birth injuries, brain tumor, tetany and the meningitides were also considered. These were ruled out, however, and the diagnosis of tetanus neonatorum was made from the typical clinical manifestations. The negative smear and culture for tetanus organisms were probably due to the presence of these organisms in the deeper tissue, where anaerobic conditions prevailed.

The following morning, the rigidity and trismus became more marked. Sodium luminal gr. ½ was given and repeated in one hour with very little, or no relaxation. Following a negative sensitivity test.

60,000 units of tetanus antitoxin were given intramuscularly, and 10,000 units were infiltrated around the umbilicus. Penicillin was increased to 100,000 units every three hours and, although we felt that the site of infection was in the deep tissue of the umbilicus, hydrogen peroxide was applied to the umbilicus every four hours. On the following day, the child's rigidity continued and sodium luminal gr. $\frac{1}{4}$ was given in the morning and repeated in the afternoon. Much more mucons was present in the child's mouth and pharynx and he was able to swallow only with great difficulty. 60 cc. of 2½% glucose in half normal saline was given subcutaneously with alidase. The child was also administered oxygen because of cyanosis, which we felt was due to the rigidity and mucons present. That afternoon, 75 cc. of 2½% glucose in distilled water was given subcutaneously. The temperature rose to 105.4° F., and 2 grains of aspirin was given rectally, along with alcohol sponges to reduce the fever. On the third day, the child was unable to take any feeding by bottle or to swallow when fed by medicine dropper. 75 cc. of 2½% glucose in distilled water with alidase was given subcutaneously during the day and sodium luminal gr. $\frac{1}{4}$ was given twice daily. The temperature remained at approximately 105° F. throughout the day, and aspirin and alcohol sponges were repeated. The rigidity was so marked by this time that an additional $\frac{1}{4}$ grain of sodium luminal was given at 7:00 P. M. and 50,000 units of tetanus antitoxin were given intramuscularly.

On the fourth hospital day, oral feeding was still impossible and 200 cc. of 2½% glucose in distilled water with B-complex added was given as a clysis using alidase. A spinal tap was done with the following results: 3 W.B.C., no R.B.C.. Smear and culture negative, trace of sugar, protein 20.6 mg. percent.

The fifth hospital day, the rigidity remained very pronounced. Streptomycin was discontinued and 100 cc. of 2½% glucose in distilled water was given by clysis. We then decided to use Mephenesin (Tolserol) in an attempt to relieve the generalized muscular spasm. This was given in the form of the elixir which we diluted to one-half strength and administered with a medicine dropper. The first dose of 0.3 gr. was given at 1:00 P. M. At 3:00 P. M. the nurse reported that the baby could open his mouth and suck the nipple of his bottle fairly well. At this time the baby was much less rigid and was able to open his mouth approximately 1.5 cm. This dosage of Tolserol was first administered three times a day, but since the antispasmodic effect was only transitory, the drug was then administered at four-hour intervals. The following morning the spasticity was even less pronounced, except for the right hand. The degree of trismus was less marked and the child was able to open his mouth voluntarily, making oral feeding possible. There also was some active motion of his upper and lower extremities and his thighs could be

flexed about 15°. By the next day (the sixth hospital day), there was no marked trismus, the thighs could be passively flexed about 90°, and some voluntary motion was present in all extremities. The umbilicus appeared infected and reddened. A blood count revealed: W.B.C. 8,200; R.B.C. 3,650,000; Hgbn. 75%; Polys 40%; Lymphs 54%; Monos 1%; Eos. 5%.

The child's condition continued to improve and he was taking his formula slowly, but well. He developed a mild upper respiratory infection with a large amount of mucons in the nasopharynx, but remained afebrile. At this time, five days after the beginning of Tolserol therapy, the patient had gained two ounces and was progressing satisfactorily. Two days later, however, we discontinued the use of Tolserol in order to more clearly evaluate its effect. Eight hours after it was discontinued, the upper and lower extremities became more spastic, the child cried almost constantly and some difficulty in swallowing developed. Two hours later the spasticity was even more pronounced, and the infant could be lifted by his feet and head simultaneously without any bending of the neck or body. At this time his temperature was 101° F., the trismus was more marked and he was unable to take any nourishment orally. Twelve hours after it was discontinued, Tolserol was given every four hours. The child was also started on aureomycin.

The following morning a five ounce weight loss in the past twenty-four hours was noted. The spasticity was still pronounced, but not as severe as the preceding night. He was started back on oral feeding. The following day the child was more relaxed, the neck was not rigid and the thighs could be flexed about 45°. At this time he was sleeping most of the day and was taking his formula well again.

His condition continued to be good and he progressed well without any further difficulty. On the thirteenth hospital day, Tolserol was increased to 0.1 gram every three hours and this dosage was continued until the sixteenth hospital day, when the drug was discontinued. At this time the child weighed eight pounds and nine ounces, six ounces more than the date that Tolserol was first administered. The patient was discharged November 28, 1950, weighing nine pounds and one-half ounce and clinically well, 24 days after his admission.

During the period of Tolserol administration, frequent blood counts were done and no tendency toward agranulocytosis or leucopenia was encountered with the dosage we used.

SUMMARY:

A case of Tetanus Neonatorum was presented. We feel that the use of Mephenesin (Tolserol) was of great value in the relief of the trismus and other muscular spasm encountered in this case.

Dissecting Aneurysm Of The Aorta

REPORT OF A CASE

RICHARD S. POLLITZER, M. D.
Spartanburg, S. C.

D. K., a 69 year old white male, was admitted to a hospital on March 14, 1950 complaining of severe chest pain. He stated that a few minutes after waking up that morning, he had had sudden severe pain in the chest which was retrosternal, and which he described as being so sudden in onset that he felt as if he had been "hit in the chest with a base-ball bat." This was accompanied by dyspnea. By the time he arrived at the hospital, he was having some pain in the epigastrium.

PAST HISTORY: The patient had had dyspnea, ankle edema, and retrosternal pain on exertion for several months.

PHYSICAL EXAMINATION: The skin exhibited an ashen-gray cyanosis. Blood pressure was 70/40. The pulse rate was 120. Heart sounds were faint. Moist rales were audible. The liver edge was palpable 3 finger breadths below the right costal margin. The abdomen was soft. The patient appeared dyspneic, and seemed to be in severe pain.

ACCESSORY CLINICAL FINDINGS: Hemoglobin 13.1 grams. Erythrocyte count 4,660,000. Leukocyte count 34,400. Differential: segmented neutrophils 72, bands 16, lymphocytes 9, monocytes 3. The E.K.G. was described as "unremarkable."

COURSE IN HOSPITAL: The patient was anuric throughout his hospital stay. He was given 300 cc. of plasma and 500 cc. of whole blood, and placed in an oxygen tent. His pain continued to progress inferiorly and ultimately involved his legs. He complained of a feeling of being paralyzed. His pain was so severe that large doses of narcotics were required. He developed marked dilatation of the veins of the neck and lower extremities, exhibited a rapidly progressive down-hill course, and expired about 6 hours after the onset of his pain.

AUTOPSY FINDINGS

At autopsy, the aorta exhibited a dissecting aneurysm. There was a thick hemorrhage into the media, which extended from a point about 2 cm. above the aortic valve, over the arch and down through the thoracic portion of the aorta on into the abdominal portion as far as the renal artery. The separation involved almost the entire circumference of the aorta. There was extensive intimal atherosclerosis of the aorta, but no definite point of rupture could be seen connecting the intima with the split in the media. The adventitia exhibited a transverse lesion about 1.5 cm. long, and located just above the origin of the aorta, on its anterior surface. This lesion communicated with the split between the layers of the media and probably allowed blood to pass into the epicardial fat, and possibly into the pericardium.

Microscopic sections from the aorta showed that the split involved the outer half of the media of the aorta, so that a layer of blood was present in the media.

The pulmonary artery showed a small amount of extravasation into its media for a very short distance, but this apparently was due to the blood having dissected down to the base of the heart and then upward in the wall of the pulmonary artery.

There was a hemopericardium, the pericardial cavity containing about 400 cc. of dark blood, most of which was liquid. The heart was enlarged; there were areas of bloody discoloration at the base of the heart, with hemorrhage into the epicardial fat. Left ventricular hypertrophy was present. Sections from the myocardium showed petechial hemorrhages between muscle fibers, and there was some scarring near the apex.

The left lung showed an extravasation of dark blood between its lobes and both lungs showed some congestion with heart failure cells being present.

The mediastinum generally showed extravasation of blood into its tissues. The kidneys show some thickening of the arteriolar walls, and there was hemoglobin in the tubules.

DISCUSSION

Dissecting aneurysm of the aorta is said to occur in about 2 to 5 cases in every 1000 autopsies.¹

Generally, examination reveals a defect or a tear in which blood enters the media and separates it into two layers; this usually occurs 1 to 2 cm. above the aortic valve.²

It is said that this point is under stress as a supporting structure for the heart; also, the pressure in the aorta is exceedingly high at this location. Hypertension is a common precursor of dissecting aneurysm of the aorta. An atheromatous ulcer may also be the site of rupture; but syphilis is an infrequent cause.²

Schlichter states that the evidence points toward local ischemia as the cause of these dissecting aneurysms. He suggests the following four possible means:

1. Obstruction of the vasa vasorum, especially by arteriosclerosis.
2. Dilatation with stasis as in shock, also vasoconstriction of the vasa vasorum by epinephrine.
3. Diminished oxygen saturation.
4. Congenital anomalies.³

Certainly hypertension alone does not seem to be an adequate explanation. The normal aorta will withstand a pressure of 1000 to 2000 mm. of mercury; so it seems likely that there must be some degenerative change or factor present in addition to the hypertension.¹

It is noteworthy that in many of the cases of dissecting aneurysms no intimal tear is demonstrable.¹

In one series of 5 cases of rupture of the aorta, all 5 cases showed a "peculiar" non-inflammatory degeneration of the media.⁴

In another series of 3 cases, all showed medial changes consisting of an increase in a homogeneous, pale-staining, basophilic, acellular material in the media. These cases were reported by Moritz, and are believed to represent medio-necrosis aortae idiopathica cystica.⁵

Medial degeneration of the aorta was noted in 95 out of 210 aortas from routine autopsy material by one author.⁶

The same author has stated that lesions consist of loss of muscles, elastic tissue, and collagen, without inflammatory reaction; healing is said to take place by loose scar formation and by regeneration of muscle and elastic tissue; he believes that possible predisposing causes include old age, heart disease or hypertension.⁷

In another series of 5 cases, 3 of which showed no intimal tear, it was believed that the underlying pathology started with degeneration of the aortic wall, especially the media; it was suggested that the vasa vasorum gave way, and that a hemorrhage formed about one of these ruptured small arterioles, with extension by pounding of the intima upon it.⁸

Winternitz is also of the opinion that dissecting aneurysm arises from hemorrhages within the vessel wall.⁹

Various experimental methods have been devised to study these lesions; for example, dogs have been given histamine to produce shock; those that survive develop degenerative, cystic and calcifying lesions in the aorta, and these are located mostly in the media.¹⁰

One investigator used a hot iron to coagulate the adventitia of the aortae of dogs; these vessels were then examined at intervals of 6 hours up to 6 days. The early changes included edema in the inner third of the media, and small hemorrhages in the outer third. The outer and middle thirds showed necrosis, and the inner third developed necrosis and cyst formation followed later by collagen fiber replacement.¹¹

In another study, rabbits were given diphtheria toxin in various doses. In the early stages, the intima showed merely wrinkling. Further advancement of the process showed thinning of the media with wrinkling of the adventitia, and in the late stages the aorta was greatly dilated, showing fissures in the intima.¹²

Microscopically, the media showed degeneration first which involved the muscle fibers, and the cytoplasm was swollen and looked flocculent. Later on, the nuclei of the muscle cells showed pyknotic nuclei followed by swelling of elastic fibers with tendency of the elastic laminae to lie close together. Calcification was occasionally seen.¹²

Although dissecting aneurysm is usually fatal, patients have been known to survive; Fisher's case showed an incompletely ruptured aorta which was

healed.¹³

The symptomatology is that of a rapidly progressing vascular occlusion. Reisinger states that the symptoms include agonizing, tearing pain which usually begins in the mid-chest, but later involves the shoulders, back, abdomen, and legs. Patients may exhibit fever, vomiting, circulatory collapse, leukocytosis, anemia, and an elevated icterus index. There may be oliguria, azotemia, albuminuria and hematuria. The E.K.G. may show a decreased QRS voltage with occasional changes in T 2 and 3, with depression of ST 1 and 2, and elevation of ST 3. X-ray may show serial changes manifested by widening of the mediastinal shadow.¹⁴

Hamburger says that the E.K.G. shows changes characteristic of coronary occlusion. In his series, several of the patients had fainting as a symptom, rather than pain; in one of the cases, there was increased pulse volume in the carotid artery, which was thought to be due to a spontaneous aortic periarterial sympathectomy performed by the blood in the media.¹⁵ One wonders, however, whether this may have been a case in which the dissection began in the abdominal aorta and had the physiological effect of a coarctation.

In the diagnosis of this dissecting aneurysm, angiocardiology may be of some help. Golden and Wrens have recently reported a case of a patient who had had symptoms for about 3 weeks and in whom angiocardiology showed thickening of the aortic wall. Operation was performed, and the patient responded nicely to therapy. These authors warn that this procedure should not be used in the acute states of dissecting aneurysm because of the risk of rapid injection of diodrast.¹⁶

COMMENT

The recent work of Schlichter, referred to above, indicates that decreased oxygen supply to the arterial wall may play some part in the pathogenesis of this condition; and the opinion of Winternitz, that the condition arises from a hemorrhage within the vessel wall seems to be in accord with this. Inasmuch as no communication between the lumen of the aorta and the false lumen of the media could be demonstrated in this patient, it seems possible that a small hemorrhage may have originated in the media of the aorta, and this may have extended up over the arch and downward, in a period of a few hours. It seems likely that arteriosclerosis and hypertension must have played some part in the causation of this hemorrhage.

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Carcinoma Of The Cervix Uteri*

LAWRENCE L. HESTER, JR., M. D.

Medical College of the State of South Carolina

Department of Obstetrics and Gynecology

Each year untold hundreds of women suffer from carcinoma of the cervix uteri. They not only endure the ravages of the disease itself, but tolerate the treatment. This is not a disease of the aged, but may occur at any age. Heckel recently reported adenocarcinoma of the cervix occurring in 2 young girls aged 7 months and 11 months.¹ Epidermoid carcinoma of the cervix is infrequent in the later teens and early twenties but may occur. The possibility of carcinoma of the cervix should never be eliminated solely on the age of the individual.

The incidence of carcinoma of the cervix is higher in married women, regardless of childbirth. In a recent study by Maliphant the probability of development of cervical cancer vary from one in 21,000 for single women, one in 6,500 for childless married women, to one in 1,500 for parous women.²

I will not burden you with a classification of carcinoma of the cervix, but simply state that there are two main types plus a combination of the two. The most frequent type is epidermoid or squamous cell carcinoma of the cervix. This arises from the squamous epithelium usually at the junction of the cervix with the endo-cervix. When we speak in general terms of cancer or carcinoma of the cervix, this is the type that we imply. Next in frequency in adenocarcinoma of the cervix which arises from the cervical glands of the endo-cervix. It is of prognostic and therapeutic importance to differentiate between an adenocarcinoma arising in the endo-cervical canal and one that has invaded the cervix, but originated in the endometrium. The third type of cancer of the cervix is adenoacanthoma which contains both glandular and squamous elements.

There are three chief signs and symptoms of carcinoma of the cervix: 1. bleeding 2. abnormal vaginal discharge 3. pain. The chief sign is bleeding and this

is usually the first sign. It may be slight contact bleeding following coitus, douching, or simple pelvic examination. Not only is vaginal bleeding our first sign, it is also our most common for in an evaluation of 1,939 cases Dr. Meigs from Boston found that vaginal bleeding occurred in 86% of the cases.³ This bleeding was usually intermenstrual or post-menopausal rather than hemorrhagic and was often post-coital. Any post coital, post douching, or post-pelvic examination bleeding must be taken seriously regardless of the age of the female. One must remember that this is usually our first sign of carcinoma of the cervix and cannot be dismissed without adequate pelvic examination which includes vaginal spreads or biopsy. Since vaginal bleeding is due to destructive ulcerative changes, it may be expected to become more frequent and more profuse as the disease advances and this is the case. Unfortunately in a few cases bleeding does not occur until the disease has obtained a fairly good foothold into the lymphatics, so even an alert and intelligent patient may be doomed before the symptoms start.

The second sign is an abnormal vaginal discharge, usually watery, which may be noted even before the appearance of bleeding, especially in adenocarcinoma. The study of Meigs quoted above had the abnormal vaginal discharge present in 32% of the patients.³ Sooner or later; however, such a discharge becomes tinged with blood. As the disease progressed both the bleeding and the discharge become more persistent and profuse and the increasing ulceration and secondary infection makes the discharge increasingly offensive. An offensive discharge is usually present in terminal or near terminal cases of carcinoma of the cervix and is of much distress to the patient because she cannot keep herself clean.

Another symptom is pain. I want to emphasize that pain is not an early symptom of carcinoma of the cervix but a symptom of late carcinoma of the cervix.

*(Presented at Annual Meeting, Myrtle Beach, 1951)

The same series quoted previously showed that pain occurred in 42% of the cases reviewed and was located chiefly in the pelvis or lower abdomen but occurred also in the back and to a lesser extent the hips, legs, and thighs.³ Pain of the lower back, or of one or both lower extremities is not uncommon, and is evident of pelvic involvement by peripheral spread associated with some degree of inflammation. Pain in the lumbar region, particularly when associated with pain deep in the pelvis and groin is characteristic of ureteral stenosis. Vaginal extension with ulceration produces pain and tenderness into the vagina which may vary with the extent of the involvement and the pain threshold of the patient. Pain in the bladder, frequency, or frank hematuria results from anterior spread or pressure. Pain in the rectum, constipation, or bulging hemorrhoids may be a sign posterior spread or encroachment upon the rectum. One still sees patients with recto-vaginal fistulae who seek help in the late stage. Still more advanced cases with distant metastases beyond the pelvis give rise to pain in the location of the metastasis.

One very frequent and important symptom of cervical cancer has not been mentioned, which has a large bearing upon the adaption of the patient to the treatment. This is fear. Most women who finally seek advice because of vaginal bleeding, discharge, or pelvic pain, have a fear of cancer. One cannot hope to gain the confidence of a patient whom he proposes to treat if he begins the relationship by deception.

As one can easily see there are few signs and symptoms of carcinoma of the cervix; therefore, it is imperative that none of these signs and symptoms go unheeded. Eighty to ninety per-cent of patients have carcinomatous extension beyond the cervix when the patient is first seen by a physician.

The treatment of invasive carcinoma of the cervix is irradiation. The surgery that is now being done is experimental and only the passage of time will tell if the 5 year survival rate is increased by surgical intervention.

The 5 year survival rate with irradiation is as follows:

	Meigs ³	24 Clinics ⁴	Holt Radium Inst. ⁵
Stage I -----	58.6%	59.6%	68%
Stage II -----	27.5%	41.2%	43%
Stage III -----	6.9%	22.9%	26%
Stage IV -----	3.0%	6.2%	5%
All Stages ----	21.5%	30.9%	29%

It is interesting to note the high stage II and stage III 5 year survival rates as reported by the 24 clinics and the Holt Radium Institute. However, the survival rates for 5 years is not higher than other clinics report. In computing 5 year survival rates we include those patients who later die of recurrences; so the statistics do not always give the true picture.

It is quite easy to see from the statistics just reported

that the 5 year survival rate with irradiation for invasive carcinoma is approximately 30% in the best clinics in the country. Five year survival rate for surgery or surgery plus irradiation is 40% as quoted by Bonney in England⁶ and 32.1% as reported by Schlink from Australia.⁷ It is to be noted that Bonney's statistics include only those cases that are operable and does not include the 37% with widespread extension (stage III and stage IV) that he considers nonoperable. These percentages are not good and offer little hope to a person having cervical carcinoma, especially if it is stage III or IV.

How are the present 5 and 10 year results to be improved? One realizes that the survival rate from surgery or irradiation or both can only be increased slightly with improved facilities, techniques, etc. In the future some chemotherapeutic agent may be discovered or developed to eradicate carcinoma but what can one do today to increase the survival rate? The 5 year survival rate can be increased greatly if carcinoma of the cervix is diagnosed and treated before it becomes invasive. Non-invasive carcinoma of the cervix, carcinoma-in-situ, intra-epithelial carcinoma, potential or convert carcinoma, or pre-invasive carcinoma all refer to the same disease process. I shall refer to it hereafter as intraepithelial carcinoma of the cervix. It is now believed that carcinoma of the cervix is a neoplasm with prolonged initial phase during which time it is confined to the covering epithelium.⁸

It must be emphasized that there are no signs and symptoms of intraepithelial carcinoma of the cervix uteri and it cannot be clinically suspected on palpation or visualization of the cervix. Gynecological symptoms and signs may be present with intra-epithelial carcinoma, but they are usually due to a co-existing disease such as fibromyomas and cervicitis chronic. If a cervical lesion is present and there is some form of vaginal bleeding, one has to assume clinically that carcinomatous invasion beyond the basement membrane has taken place.

How can the diagnosis of carcinoma of the cervix be made before invasion has taken place? It can only be made by routine smears or cervical scrapings, sponge biopsy, or biopsy of *every* adult female who presents herself at a physician's office. Emphasis must be placed on *every* patient, for unless we make this procedure or procedures routine, intraepithelial carcinoma of the cervix will continue to be passed by until it has become invasive. If there is a cervical lesion present, then biopsy should be done in preference to a cervical smear, for here there is a definite lesion to be examined. However, one should remember that only one small area is being examined on a biopsy and the pathologist cannot be held responsible for changes that are taking place only a few millimeters away. If the cervix is clean then a cervical smear should be done as a routine part of the pelvic examination. A cervical smear obtains a sampling of the epithelium of the entire cervix and thus is superior

to the biopsy. A sponge biopsy (gladstone sponge) is usually used with a biopsy when there is vaginal bleeding, and in post-radiation cases where it is quite difficult to obtain cervical scrapings. Foote and Stewart's article⁹ on the anatomical distribution of 27 intraepithelial carcinomas of the cervix supports routine cervical scrapings even in the presence of cervical lesions. Based on their anatomical studies, if one selected for biopsy the central junctional area of the anterior or posterior lip, either one of these two sites would have produced about thirteen positive pathological reports. If specimens were simultaneously taken from both these locations, twenty of the twenty-seven cases would theoretically have been reported as positive. If, in the biopsy scheme, additional material was also taken from the lateral angles of the external os, twenty-five of the twenty-seven cases would presumably have been reported positive. Two of the lesions were of the endo-cervix and could not be diagnosed by cervical biopsy.

Foote and Stewart's article⁹ is not included to reflect critically on the biopsy, for actually there were more routine negative smears in this study. It is supposed to show the limitations of the biopsy and the best areas in which to take a routine cervical biopsy with or without a cervical lesion. As mentioned previously, the cervical smear in no way supplants a biopsy. There is no justification for doing a smear instead of a biopsy; however, there are adequate reasons for doing a smear in conjunction with a biopsy. These are two distinct laboratory methods of diagnosis that have definite indications. They supplement each other instead of one supplanting the other.

It is mandatory that a positive smear or a suspicious smear be further investigated before therapy is begun. There is no excuse to begin therapy until the extent of the carcinoma is determined. A positive smear in no way indicates whether or not a lesion is invasive, or the amount of the invasiveness. It is ideal to have multiple sections from a surgical conization of the cervix before therapy is instituted.

The practice of taking a biopsy or smear of the cervix followed by immediate cauterization is to be condemned. Cauterization should not be done until a pathological report is received, for more cervical tissue for microscopic examination may be requested. Cauterization destroys tissue and prevents an adequate evaluation of the cervix to be made if further study is desired.

I have presented certain idealistic proposals to increase the 5 year survival rate of carcinoma of the cervix. These proposals will have to remain idealistic until we have more laboratories with pathologists trained in the cytological examination of cells. These laboratory procedures are further limited by the cost of the test and the capability of the patient to pay.

CONCLUSIONS

- 1) There are no signs and symptoms of intra-epithelial carcinoma of the cervix uteri.
- 2) The detection of intraepithelial carcinoma is meticulous, time consuming work, 99% of which shows negative results.

- 3) Cervical smears or biopsy are a must with each routine physical or gynecological examination.
- 4) The cervical smear supplements the cervical biopsy and does not supplant it.
- 5) The 5 year survival rate for carcinoma of the cervix can only be markedly increased by diagnosing the lesion before invasion has taken place and instituting appropriate treatment.

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DISCUSSION

by Dr. G. Fraser Wilson, Charleston, S. C.

Dr. Hester has pointed out the advantage of making an early diagnosis of carcinoma of the cervix and of beginning treatment before the carcinoma becomes invasive. He has told us how the five year survival rate can be increased and he has listed valuable laboratory procedures that are available to all of us practicing in South Carolina today.

I believe that it is impossible to over-emphasize the role we practitioners should play in early cancer detection. Even with more laboratories, more trained pathologists, we are still the first line of defense in the fight against carcinoma of the cervix. Early cancer detection in the office of the physician is the solution to the problem. As time goes by we will find that the ideal cancer detection centers are in our own private offices.

We all know it is difficult to biopsy or obtain Papanicolaou smears from every patient with cervicitis or to subject an apparently well woman to the cost of these laboratory procedures. At the present time, however, they are the only available means we have at our disposal to diagnose early carcinoma. Failure on our part to make the diagnosis after the patient has presented herself for examination is the weak spot in our fight against carcinoma.

Adequate periodic examinations of apparently normal women is the only way to lower the incidence of this disease and to make the diagnosis before the carcinoma becomes invasive. The women of South Carolina are being educated to the advantage of a yearly physical examination and the number of women requesting examinations of this nature is steadily increasing. They are aware of the fact that carcinoma is no respecter of age, parity or social status and they depend on us, the private practitioners, to protect them from the suffering and ravages of this disease which Dr. Hester has described so well for us today.

The Care Of Hand Injuries*

OPEN FRACTURES

Major wounds of the hand may be caused by crushing or tearing injuries, injuries from explosions, or by the impact of foreign bodies. Such wounds may involve damage to skin by burning or avulsion, laceration of soft tissues, and open injuries of bones or joints. The purposes of early treatment are:

- (1) Relief of pain and shock
- (2) Arrest of hemorrhage
- (3) Protection against infection and further injury
- (4) Removal of foreign bodies and dead tissue
- (5) Conservation and restoration of damaged structures
- (6) Early healing
- (7) Restoration of function

A. First-aid treatment

1. Application of voluminous sterile dressing without interference with the wound, the hand being placed in the position of function.
2. Hemostasis can usually be obtained by pressure gently applied to such a dressing. A tourniquet is rarely needed, but may be employed briefly to check brisk, continuing blood loss.
3. Shock and pain may require appropriate treatment.
4. The hand, in initial dressing applied as above, is splinted in position of function for transportation to adequate surgical facilities. (See Article II)

B. Definitive treatment

1. If bones or joints are thought to be involved, preliminary x-ray views are made without disturbing the initial dressing.
2. Patient is treated systemically for pain, shock and hemorrhage; antibiotics and tetanus antitoxin (or toxoid booster) are administered, and the patient prepared for operation.
3. In operating room, with patient anesthetized, dressing is removed.
4. With the wound carefully protected, the arm, forearm, and hand are scrubbed, shaved and draped.
5. The skin wound and the area about it are carefully and gently cleansed with soap and water or mild detergent (no antiseptics) and the entire wound examined. Bleeding vessels are ligated.
6. Foreign material and devitalized tissue are accurately trimmed away.

This procedure aims at thoroughness, but must strictly conserve the maximum of viable tissue. It is particularly important to preserve skin and all bone fragments which are not completely free and displaced.

7. Repair of soft tissue injuries is governed by criteria of length of time since injury and of the degree and nature of contamination. (See Article IV) Where conditions are favorable (i. e., in relatively clean wounds not more than three or four hours old), initial repair may be effected within limitations described in Article IV.

Even in unfavorable cases, severed nerves should be united if possible, or at least identified by long sutures of stainless steel.

8. Dislocations of joints, if open in the wound, are reduced.
9. Bone fragments in the open wound are restored as nearly as possible to normal position, but without fixation by foreign material. In some instances the employment of stabilization with a minimum of stainless steel wire is justifiable if required to maintain reduction.
10. Maintenance of reduction of open fractures may usually be obtained by skeletal traction or appropriate splinting. (See Article V) If required, pins for bone fragment fixation or skeletal traction are applied as there described.
11. Maximum skin closure is effected. (See Article IV) Particular care is taken to cover bones, joints, tendons and nerves. Where required, pedicle skin grafts (local or from abdominal wall) may be used for coverage unless established or inevitable infection forbids.
12. Pressure dressing is applied and the hand splinted as required for optimum control of its repaired injuries, approximating as closely as possible the position of function. (See Articles IV and V) Flat splinting is to be avoided. Uninjured parts of the hand should be left free for movement. The hand is kept elevated.

C. Subsequent dressings

These are managed with regard to the following factors named in the order of their importance:

- (a) Control of infection, adequate drainage;
- (b) Establishment of bony union and joint healing;
- (c) Early completion of skin coverage and healing.

1. The establishment of infection in the wound may require early and frequent dressings to insure its control. These should be done under aseptic conditions and in such manner as not to disturb the corrected position of injured bones or joints.
2. Large skin defects should be covered by grafting at the earliest moment compatible with the maintenance of position of corrected bone and joint injuries. (See Article III)

*Note: This is one of a series of articles on "The Care of Hand Injuries." This material is prepared by the American Society for Surgery of the Hand and is distributed by the Committee on Trauma, American College of Surgeons, through its Regional Committees.

D. Restoration of function

Following healing of skin and soft tissues and firm union of bony structures, as much function as possible should be restored by directed active use of the hand, therapeutic exercises and occupational

therapy.

Reconstructive surgery is often required after such injuries to permit maximum restoration of function. Such reconstruction will be less extensive and less formidable if the early management of the injury is judiciously and carefully carried out.

CANCER

Edited by HENRY W. MAYO, JR., M.D., Charleston, S. C.

RADIOISOTOPE PROGRAM OF THE MEDICAL COLLEGE OF THE STATE OF SOUTH CAROLINA

WILLIAM M. MCCORD, M. D.

JOHN C. HAWK, JR., M. D.

HUMPHREY K. EZELL, M. S.

In 1949 a program for the use of radioisotopes was instituted at the Medical College of the State of South Carolina. In compliance with the requirements of the Atomic Energy Commission a Committee, composed of various medical specialists, was appointed by the President of the Medical College to supervise the program and to exercise control and safety measures for the best interests of both patient and physician. This Committee was authorized initially to use four isotopes: iodine, phosphorus, sodium and iron. However, the Committee decided to limit the activities of the program at first to the use of radioactive iodine (I^{131}) and phosphorus (P^{32}) because more was known of these isotopes, because their physical characteristics made them safer and easier to handle, and because their use promised to have more general application than did the use of other isotopes.

Any isotope with a short half-life decomposes rapidly, making it necessary to set up a closely coordinated program regarding shipments of the isotope and scheduling of patients. Such an isotope in general, however, is safer to use in that exposure time is limited to only a few days. Isotopes with longer half-life periods are easier to use but exposure periods, after absorption, may be dangerously long if they are not excreted rapidly, and if they are deposited more or less permanently in the tissues. On this basis, I^{131} , with a half-life of eight days and P^{32} , with a half-life of 14.3 days, are very satisfactory for they can be shipped conveniently without too much loss during the period of transit and also, even though absorbed and deposited, will not give exposure times of dangerous length.

Supplies of I^{131} and P^{32} are obtained at regular intervals from the Oak Ridge National Laboratory in special containers, by Air Express. Upon arrival, the radioactive material is diluted to a standard con-

centration and the concentration measured and checked against the value submitted with the material. This procedure serves as a double check upon the strength of the radioactive material and also as a check upon the accuracy of the measuring instruments in this laboratory. As a further check, each day before use the instruments are calibrated against standard samples of radium and at intervals of three months against standard samples of I^{131} and P^{32} supplied by the United States Bureau of Standards. After dilution and standardization, the I^{131} or P^{32} is ready for administration to patients.

The choice of patients is the responsibility of the Committee upon the request of the physician referring the patient. As a general statement, the possible advantages to the patient are weighed against the possible dangers. On this basis, the Committee is reluctant to allow the administration of radioisotopes in therapeutic dosages if further surgical or medical procedures could conceivably be helpful. However, if further surgical or medical procedures are apparently impossible or inadvisable and if the administration of radioisotopes could be useful, no objection is raised, provided proper controls and safeguards are observed. A standard procedure has been developed which seems fairly satisfactory to all concerned: Any patient who is considered by his physician to be a candidate for radioisotope therapy may be referred to the Radioisotope Committee. After complete medical work-up, a tracer study, with either I^{131} or P^{32} , is performed, using 50 to 100 microcuries, to determine the localization potentialities of the tissue concerned. This study requires 48 hours and therefore hospitalization is strongly advised. The entire body is surveyed 24 hours and 48 hours after administration for localization of the radioactive isotope. Urine is collected at each voiding, and at the end of the period the individual urine samples are assayed for excreted isotopes. On the basis of this data and the patient's clinical picture, a decision is made regarding the advisability of giving a therapeutic dose. The desirability of the administration of therapeutic doses varies with two factors: the localization of the radioactive isotope in the specific tissue, and the sensitivity of the specific tissue to radiation. Usually it is considered useless or even unwise to attempt radiation with isotopes of types of tissues resistant to

This program is supported in part by a cancer training grant from the National Cancer Institute of the National Institutes of Health, U. S. Public Health Service.

From the Cancer Clinic and the Department of Chemistry, the Medical College of the State of South Carolina, Charleston, South Carolina.

radiation or of tissues which do not selectively pick up the particular isotope used. Assuming that localization and sensitivity are favorable, the isotope is given by mouth in water solution. The patient is observed for 48 hours, the urine assayed and the whole body again surveyed for radioactivity. The patient may then return to his home for observation by his family physician and should have periodic examinations and blood surveys. At intervals of two to three months he should return for observation and for possible repetition of therapy. In some instances patients may be referred to the Medical Division of the Oak Ridge Institute of Nuclear Studies for the initial or even the entire period of treatment.

The facilities of the Radioisotope Program have been used in the following types of cases:

TRACER STUDIES:

- I131: Localization of aberrant thyroid tissue, such as sublingual and substernal thyroid tissue. Localization of metastases of thyroid carcinoma. Estimation of activity of thyroid in suspected hyperthyroidism and hypothyroidism.
- P32: Localization of intracranial tumors. Blood volume studies.

THERAPY:

- I131: Advanced metastatic thyroid carcinoma. Selected cases of hyperthyroidism.
- P32: Polycythemia vera. Leukemia, Hodgkin's disease, lymphosarcoma.

Again it should be emphasized that only those patients for whom conventional therapy seems to offer no further benefit are accepted for treatment and then only if radioisotope therapy gives promise of definite improvement. In some particular and special circumstances a few other types of patients, not included in the above list, have been examined and some have been treated.

The danger associated with the use of radioisotopes is similar to the danger associated with the use of any potent drug or procedure. Overdosage or ill-advised or ill-timed administration may result in undesirable consequences which may not become apparent until considerable time has passed. The dosages used in this program so far have been small, tending specifically toward the conservative side. The radioactivity present in tracer doses approximates the activity in the average luminous wrist watch dial face and is completely dissipated in a matter of days. Therapeutic doses are higher and theoretically they might produce symptoms of radiation toxicity. However, by suitable dosage at suitable intervals, usually not oftener than two to three months, no untoward symptoms would be expected. To date, there have been no reported cases of interference in gene structure following the use of these isotopes. In this pro-

gram, however, therapeutic doses of radioisotopes will not be administered to females in the childbearing age group until this type of reaction is more fully understood. At present the knowledge of the effect of this type of radiation is based almost entirely upon information obtained from the action of Roentgen rays and little investigation has been done upon the action of the radioisotopes themselves. Programs of investigation upon the action of radioisotopes, after being absorbed and assimilated into the cells, are under way in various laboratories. Until such investigations are complete, considerable care necessarily will be exercised in the use of isotopes.

In some special respects there are advantages in the use of radioisotopes over the use of x-ray or radium. With the use of isotopes the radiation occurs within the involved tissues and should not affect large areas of skin and other tissues. This is only true, of course, of those isotopes which are well localized, such as iodine in the thyroid and iron in the red cells. Furthermore, isotopes can be conveniently employed to give a low dose of radiation over a longer period of time. The action of radioisotopes, however, cannot be "turned on and off" as is possible in x-ray therapy. Once administered, their effect continues until their decay is complete or excretion occurs.

Specialized procedures are now being developed which may increase the range of application and effectiveness of isotopes. Drugs and hormones may stimulate absorption or excretion of particular elements, thus affording a method of partial control of administered isotopes. In some cases the isotopes may be incorporated in the drugs themselves. Other isotopes are being tried because of particular chemical and physical characteristics, such as colloidal gold, which is not absorbed and which, therefore, confines its action to the site of injection, as in a serous cavity.

The Medical Division of the Oak Ridge Institute of Nuclear Studies is currently studying the use of radioisotopes in a variety of conditions. The Director of the Medical College Cancer Clinic, in his capacity as a consultant of the Medical Division, is authorized to make arrangements for referral of patients from the State of South Carolina to Oak Ridge for radioisotope therapy. At the present time the following types of patients may be referred for treatment at Oak Ridge:

1. Carcinoma of the prostate with bone metastases of osteogenic type in patients who are no longer helped by standard therapy.
2. Osteogenic sarcoma with inoperable metastases.
3. Carcinoma of the thyroid not amenable to surgical therapy.
4. Pleural metastases from any type of carcinoma in which recurrent pleural effusion is the main problem, preferably without massive intrapulmonary lesions.
5. Carcinomatosis of the abdomen in which ascites is the cause of most of the symptoms.

6. Active Hodgkin's disease, previously treated; patients for whom there is not satisfactory treatment, but who are not terminal.

7. Multiple myeloma.

8. Chronic myelocytic leukemia.

9. Polycythemia vera.

10. A few patients with metastatic malignant melanoma who are in fairly good general condition and who have lesions suitable for multiple biopsies.

Any physician in South Carolina who has a patient who might fit into one of these categories should contact the Director of the Medical College Cancer Clinic

for consideration of referral of the patient to Oak Ridge.

The Radioisotope Program of the Medical College is still in the formative stage and the number of patients examined and treated thus far is not sufficiently large to permit statistical evaluation of the results. Rapid expansion of the program is anticipated in the future, for with the completion of the new Medical College Laboratory Building (Fall, 1952) truly adequate facilities for a radioisotope laboratory will become available and will permit not only more extensive employment of the isotopes now in use but also the addition of other isotopes within the scope of the program.

ANNUAL MEETING

MYRTLE BEACH

MAY 13, 14, 15

Tuesday, May 13—10 A. M.

House of Delegates Convenes

Wednesday, May 14—2 P. M.

Scientific Session Begins

Thursday, May 15—1 P. M.

Alumni Luncheon

Thursday, May 15—7 P. M.

Annual Banquet

Headquarters—Ocean Forest Hotel

THE PRESIDENT'S PAGE

The committee appointed to seek passage by the South Carolina General Assembly of a bill which would reorganize The South Carolina State Board of Health and its Executive Committee in the manner approved by the House of Delegates in the called meeting held on December 9, 1951 failed in its efforts.

Representative Robert S. Galloway presented the bill which had been drawn by Mr. Meadors to his House Committee on Military, Public and Municipal Affairs. The committee held a hearing on it. Several members of our committee attended the hearing. The committee voted to introduce the bill unchanged and it passed the House as introduced and without difficulty.

The Senate referred the bill to its Medical Affairs Committee with Senator Wm. P. Baskin as chairman. A hearing was held. Members of the State Optometric Association and of the State Veterinary Association were present to request that each organization have a member on the proposed new State Board of Health. Our association was represented by the President, the Chairman of the Committee on Legislation and Public Policy, and our Counsel.

The Medical Affairs Committee of the Senate has 16 members. Many members were not present at the hearing. The hearing was hurriedly held, because other important committee meetings were being held at the same hour and members of the Medical Affairs Committee wished to attend them. There was a short executive session of the committee after the hearing, and it was learned later that the committee voted to continue the bill. This probably means that it will die in the committee, since all bills not passed, ratified and signed during this session of the General Assembly will die, since next year the Assembly will be a new one.

As this is written, efforts have been made to secure reconsideration. District councilors have been requested to use their influence with their senators, when their senators are members of the Medical Affairs Committee. Dr. John Douglas, president of the South Carolina Dental Association, brought pressure to bear on a member of the committee who is a dentist. However, even if, as a result of these efforts, the bill should be voted out of committee, its chance of coming to a vote in the Senate are remote, since efforts are being made to rush the session to a close.

X X X

Preparations for the annual meeting are going ahead. Dr. John Rainey and his Committee on

Scientific Work have the scientific program almost completed. Dr. Julian Price's special committee to rewrite and revise the constitution and by-laws has completed its preliminary work. Other special and standing committees are getting their tasks in order.

Dr. Wyman King, president of the Alumni Association has requested that the alumni luncheon be scheduled for Thursday instead of Wednesday, as heretofore.

The House of Delegates will convene Tuesday morning, recess for meetings of reference committees Tuesday afternoon and evening and will reconvene Wednesday morning and will complete its work by one o'clock that day. The scientific session of the Association will begin after lunch on Wednesday. There will be no official entertainment on either Tuesday or Wednesday evenings, although, if the weather is warm, there will be music for dancing in the patio. These evenings will give opportunity for private parties and good fellowship. The annual banquet will be held Thursday night, at which time the President-Elect will be installed as President.

The officers of the Women's Auxiliary are casting the program of the Auxiliary to fit in with the changed arrangement of the Association meeting.

Perhaps, the two most important items of business for the House of Delegates will be the consideration of the report of Dr. Roderick MacDonald's special committee which would establish a grievance committee, and the report of the special committee on constitution and by-laws. What to do further regarding the efforts of the House of Delegates to bring about a reorganization of the State Board of Health probably will come up for discussion and decision also.

Section 12 of Chapter VIII of the By-laws requires that, "Reports of standing and special committees shall be placed in the hands of the secretary sixty days prior to the annual session of the House of Delegates, and in turn, the secretary shall have these copied and have them mailed to the delegates of the various component societies thirty days prior to the meeting." If that requirement is met, committee reports should reach the secretary by March 21, and the business of the meeting of the House will be expedited. Copies of recommendations requiring House action should be retained by the chairman so that he may present them on the morning of the first day.

J. Decherd Guess

The Journal of the South Carolina Medical Association

EDITOR: Julian P. Price			Florence, S. C.		
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Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

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MARCH, 1952

S. D. D. V. D.

We want to open a membership drive here and now for the S. D. D. V. D.—the Society for the Discouragement of the Diagnosis of Virus Disease. We have been impressed this winter more than ever before by the large number of patients whose history begins something like this—"Doctor, last summer I had a virus infection and I haven't been able to throw it off since although I've taken several million units of penicillin, all sorts of mycins and any number of shots of vitamins."

Now we are quite willing to concede that there are a certain number of genuine cases of virus infection—and certainly some of them are quite debilitating and mighty slow to convalesce, but we dare say that not more than 25% of the cases so diagnosed are true instances of virus infection; and most of those and all of the other 75% are overtreated. It is reminiscent of the years immediately following the influenza pandemic of 1918-1919 when it was professionally unbecoming to have a simple coryza or rhinitis or bronchitis—it had to be influenza.

"Virus infection" has become another diagnostic waste-basket into which we toss those cases that aren't very sick and about whose true pathological process we are quite foggy. Most often we, as doctors, merely acquiesce in the diagnosis which the patient makes himself. But once we are committed to the diagnosis of virus disease, then we are on a treadmill that grinds on and on. The patient is pretty proud of himself for having such an elite and popular disease with which he is on speaking terms. His pride soon turns to profound respect when he finds the capsules he must take in abundance cost him fifty or seventy five cents apiece; and when the first batch doesn't work he shifts to another color which is no less expensive. About that time he begins to get nauseated and maybe develops some bowel disturbance which just proves to him that now the virus has invaded the gastro-intestinal tract. Certainly we are seeing lots of patients who started out with something rather simple, got involved in a lot of treatment and end up after several

weeks debilitated, weak and unhappy and probably running the same fraction of a degree of fever they did at the outset.

We think these people *are* sick—and we think that antibiotics are as responsible as any virus for their ill health. We are all familiar with the work of numerous investigators which prove beyond reasonable doubt that the antibiotics—every last one of them—result in a pronounced dislocation of the normal bacterial flora of the upper air passages and the gastro-intestinal tract. We know that in aureomycin there is a substance which actually promotes the growth of candida albicans while the antibiotic portion of the drug destroys much of the normal bacterial flora of the intestine. We know that severe avitaminosis often develops in patients heavily dosed with antibiotics. The diarrhea which so often occurs in the course of such therapy may be due either to monilial overgrowth or to the upsetting of the balance of power which normally exists in the intestinal flora. And it takes no great stretch of the imagination for us to picture the lassitude, weakness, anorexia and chronic exhaustion of these long standing and long treated virus victims as being due to this same bacterial revolution which has taken place all over the body

Anyhow the moral is obvious. The use of antibiotics which can produce such drastic changes in bacterial flora is not to be entered into lightly. The current practice of dosing everyone who has a bit of fever, sore throat or other minor indisposition is poor medicine from every standpoint.

W. R. M.

YOUR CHANCE TO HELP

Once again the American Red Cross is affording each citizen in this country the privilege of joining in the great work which that organization is doing. Physicians, as leaders in their communities and as those whose income is well above the average, should accept this privilege with an open heart.

One has but to consider the far-flung activities of the

American Red Cross—collection of blood, rendering need in disaster areas, teaching of first aid, service at military installations, training of individuals for home nursing and for service as nurses aids in hospitals, etc.—to realize how much there is to be done and how much money it will take to operate the organization.

Give and give liberally—the American Red Cross needs your help.

SHALL WE OR SHALL WE NOT?

A special committee has been appointed to revise the Constitution and By-Laws of our Association and to bring it up to date. Undoubtedly, the committee will bring in recommendations for further amendments and changes and concerning these there should be general discussion.

Here are some of the questions which the committee is even now considering:

Should all past-presidents be entitled to membership in the House of Delegates?

Shall we have a Speaker for the House of Delegates or shall we continue our present custom of having the President of the Association preside?

Shall we have a Business Manager or an Executive Secretary?

Shall the word "white" be eliminated as a requirement for membership in the Association?

Shall we continue the plan under which the House of Delegates will meet this year—meeting on the morning of one day and the morning of the next, with reference committees meeting during the afternoon between—or shall we go back to our one day meeting?

Comments upon these suggestions will be greatly appreciated and may be sent to any member of the committee Drs. J. D. Guess, O. B. Mayer, N. B. Heyward, or J. P. Price.

GRIEVANCE COMMITTEE

Shall our Association establish a Grievance Committee? This question will be answered at the coming meeting of the House of Delegates in May.

A specific plan for the establishment of such a committee was presented at our last meeting by a special committee headed by Dr. Roderick Macdonald of Rock Hill. It was decided to allow the proposed plan to lie on the table for a year so that all could study it. It was printed in full in the published minutes of the House of Delegates in this Journal.

At our coming meeting the proposed plan will be up for adoption or rejection. Undoubtedly there will be considerable discussion, possibly certain changes, before it is voted upon. It is our sincere hope that the plan, amended perhaps in some of the minor details, will be adopted and put into immediate effect. There is need for such a plan in South Carolina and

we should take our place alongside that large group of state medical associations throughout the country who have already established a committee of this type.

COMPLAINTS OR SUGGESTIONS WELCOME

The Blue Shield Plan has set up an Advisory Committee for the purpose of securing constructive criticism. Any physicians in the Association who have suggestions or complaints regarding the fees or any other phase of the Plan, are requested to send them in to the Committee, Dr. V. Wells Brabham, Jr., Chairman, Orangeburg, S. C.

DEATHS

AUGUSTUS THEODORE NEELY

Dr. A. T. Neely, 64, died February 1, at the Baptist Hospital in Columbia following a short illness. A native of York County, Dr. Neely was graduated from the Medical College in Charleston in 1913. Following his graduation he practiced general medicine in Fort Mill for five years. He then decided to specialize in eye, ear, nose and throat work and completed his training in Baltimore. For the past twenty years Dr. Neely had practiced his profession at Newberry.

He is survived by his widow, one son and one daughter.

NEWS ITEMS

PIEDMONT PROCTOLOGIC SOCIETY

There will be a one day session of the Piedmont Proctologic Society at the Charlotte Hotel, March 29th. Any interested physicians are invited to attend this meeting and should notify Dr. C. C. Massey, Professional Building, Charlotte, N. C., or Dr. B. Richard Johnson, Raleigh, N. C.

Dr. Lawrence W. Stoneburner of Ohio and Florida, is now associated with Dr. Henry Ross of Greenville, in the practice of surgery.

Dr. Malcolm L. Marion, formerly of Chester, has been promoted to the rank of Captain in the U. S. Air Force.

Dr. Joseph W. McMeans, formerly pathologist at the McLeod Infirmary in Florence, has succeeded Dr. Ralph M. Weaver as pathologist at the Anderson Memorial Hospital.

THE TEN POINT PROGRAM

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

HEALTH BOARD REORGANIZATION BILL DIES IN SENATE

The Bill to reorganize the State Board of Health, in accord with the recommendation of the House of Delegates of the South Carolina Medical Association, went through the House of Representatives like a breeze. It was first approved by the House Committee on Public and Military affairs (which handles medical affairs) and was introduced as a Committee Bill. It passed three readings without amendment and, in fact, without an amendment being offered, although there was an effort on the part of the veterinarians in the State to have an amendment offered to include one of their number.

The Bill was read once in the Senate and referred to the Committee on Medical Affairs. Senator William P. Baskin of Lee County, Chairman of the Committee, in response to requests from one or more groups, set the matter for Public Hearing on the afternoon of Tuesday, February 12th. At the Hearing a large number of optometrists were present together with a considerable delegation of veterinarians, and each group presented to the Committee its grounds for the request that one of their number be included on the Board.

Dr. J. Dechard Guess, Chairman, Dr. W. C. Cantey, and M. L. Meadors of the Committee from the State Association, were present and Dr. Guess made a brief statement outlining the history of the recommendation and stressing the fact that the Bill was the result of the action of the House of Delegates of the State Medical Association.

The attitude of the members of the Committee who were present seemed to be favorable toward the Bill as drawn and, in fact, information received prior to the Hearing indicated that it probably would receive the Committee's approval and pass the Senate without difficulty. After the Committee's executive session, which followed the Hearing, however, we were advised that the Committee had decided to continue the matter and various reasons were given, although the actual basis for opposition was never made quite clear. Further effort was made to have the Committee consider the matter at a subsequent meeting scheduled for Wednesday afternoon, February 13th, but no action was taken and as this is written, the indications are that the Bill probably will remain in Committee and not reach the floor of the Senate for debate.

Reports current in the State House on February 12th, the General Appropriation Bill having been passed, ratified and approved, were that no additional statewide legislation would pass the General

Assembly this session. Thus far the Report has proved correct, and with almost certain adjournment scheduled within a week, it is obvious that only county supply Bills and perhaps other purely local measures will be enacted.

Two other Bills which were pending before the Senate Committee on Medical Affairs, one concerning provisions for Mental Hygiene and Mental Health, and the other to provide for the licensing of Physio-Therapists, met the same fate as did the Bill to reorganize the State Board of Health.

S. C. MEDICAL ASSOCIATION SUPPORTS HEALTH OFFICER

To the Editor of The News:

Recently, in the State House of Representatives, the State Health Officer, Dr. Ben F. Wyman, was subjected to attack, and it was charged that he was not carrying out State Board of Health regulations relating to milk and milk products. This charge appears to have been adequately refuted by a statement addressed to the members of the General Assembly by Dr. Wyman and dated January 10, 1952.

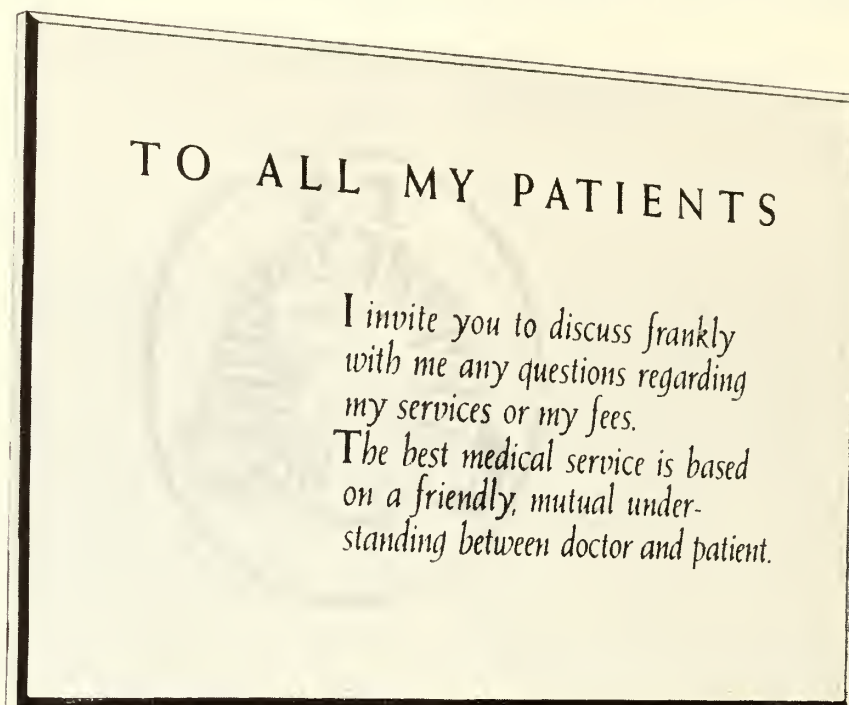
Under existing law, the South Carolina Medical Association in its corporate capacity, along with the Attorney and Comptroller Generals, constitutes the State Board of Health. By reason of that fact, the South Carolina Medical Association has interested itself in the numerous changes in the organization and administration of the health department and in the effects upon public health activities and objectives which have resulted.

The Council, the executive committee, of the South Carolina Medical Association has not only made a rather extensive study of these changes and their effects, but its members have individually and informally heard many complaints by doctors widely scattered throughout the State. These have had to do with restriction and abridgment of public health services and activities and have reflected considerable resentment over the way in which reorganization was effected without consultation and advice from the State Medical Association, acting as the State Board of Health. There has not been appreciable criticism of either the Executive Committee of the Board of Health nor of the State Health Officer. It seems to be the feeling of medical men generally that both the Board and Dr. Wyman have done the best that could be done under the restrictions imposed.

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However, the members of the Medical Association realize that great harm has been done to the administration of public health in our State. Personnel, much of which had been specially trained with public health funds, has been lost. Morale has suffered greatly. Activities have had to be restricted, and a health department of which our citizens could well be proud has become demoralized and perhaps mediocre.

The House of Delegates of the South Carolina Medical Association has prepared and adopted resolutions for presentation to the General Assembly, and there is in process of being drawn up a bill incorporating the provisions of these resolutions which seeks to modernize and to render more efficient, perhaps, the State Board of Health, and at the same time to bring about a closer relationship of the Board and political State Government. The proposed Board of Health would consist of nine individuals, to be appointed by the Governor. There would be three non-medical members representing the consumer, three doctors, one dentist, one druggist and one registered nurse on the proposed Board, which would have supervisory powers over the Health Department. The Health Department, headed by a State Health Officer selected by the Board, would be executive and would carry out health laws and regulations.

This Bill will be introduced into the houses of the General Assembly, and wide support for it is requested. To most members of the South Carolina Medical Association, its adoption appears to be a distinctly forward step. Although it will relate the Board of Health to State political government more closely, it will not throw public health matters into politics, which would be unfortunate.

Some, not familiar with the facts, have interpreted activities of the Council of the Medical Association and the resolutions addressed to the General Assembly as critical of the Executive Committee of the State Board of Health and of the State Health Officer. The contrary is the fact. Although it is realized that Dr. Wyman has made mistakes and that he has antagonized certain influential people, which is unfortunate, it is also realized that he has done an outstanding service to public health during his service and that he is a man who would be difficult to replace. The South Carolina Medical Association, both as an organization comprising most of the doctors in the State and as the State Board of Health since 1878, stands squarely behind the Executive Committee of the Board, often erroneously thought of and referred to as the Board of Health. It stands just as squarely behind the State Health Officer, Dr. Wyman.

J. DECHERD GUESS,

President, S. C. Medical Association

The Greenville (S. C.) News
January 20, 1952

A. M. A. CLARIFIES POINT REGARDING MEMBERSHIP DUES

In answer to several queries, the membership department of A. M. A. has clarified a point in connection with the payment of dues by a member who is reinstated.

A member, dropped for nonpayment of membership dues and who wishes to have his membership reinstated, would owe membership dues for the year in which he became delinquent and the year in which his membership was reinstated, but he does not have to pay membership dues for the intervening years.

Here is an example: Dr. Blank was dropped in 1951 for nonpayment of 1950 membership dues. He applies for reinstatement of his A.M.A. membership in 1952. To bring about his reinstatement, he would be required to pay his 1950 membership dues and membership dues for 1952. Membership dues for 1951 would NOT be required.

JUNE MEETING OF A.M.A. IN CHICAGO

Members who are planning to attend the annual convention of A. M. A. in Chicago, June 9-13, should find the trip well worth their while. According to a letter from the Secretary, Dr. George Lull, it seems that plans and preparations for the meeting this year are designed to make it bigger and better than ever. Here are some statistics quoted from Dr. Lull's letter which may give some idea of the effort involved in preparing for the convention:

—The Technical Exhibits would, if stretched end to end, reach nearly two miles, and the Scientific Exhibits would stretch for approximately another mile and a half.

—10,000 chairs will have to be brought into Navy Pier where the exhibits will be held.

—More than a mile of windows will be blacked-out to provide darkened rooms for lantern slides.

—Provision is being made for 8,000 hours of demonstrations in the Scientific Exhibit.

—There will be more than 220 hours of lectures in the meeting rooms.

—360 firms will exhibit drugs, foods, equipment, books and services for the busy physician.

To make the going pleasant for doctors taking in the exhibits, arrangements have been made for setting up convenient lounges where visitors may rest, relax, and chat with colleagues. For the first time, the A.M.A. is using every square foot of space available on Navy Pier.

In order for traffic within the pier to flow more smoothly, the aisles in the Technical and Scientific Exhibits are being widened to 12 feet. Broad cross aisles frequently spaced should minimize crowding and keep the exhibits well ventilated. By using the full facilities of the pier, all but two of the sections will hold their meetings there, making it unnecessary for the physician to travel from the meeting hall to hotels and back again.

AMA'S POSITION ON UMT OUTLINED TO HOUSE COMMITTEE

Following is the text of the statement of Dr. F. J. L. Blasingame on behalf of the Board of Trustees of the American Medical Association, before the Committee on Armed Services of the U. S. House of Representatives, in reference to H.R. 5904, and the Report of the National Security Training Commission, dated October 1951.

Mr. Chairman and members of the Committee:

My name is Dr. F. J. L. Blasingame. I am engaged in the active practice of medicine in Wharton, Texas and am a member of the Board of Trustees of the American Medical Association. I am appearing here today, with my colleagues, on behalf of that Association regarding H.R. 5904, 82nd Congress, and the report of the National Security Training Commission.

At the outset, let me say that our purpose in appearing before the Committee is to make certain suggestions relative to the medical aspects of Universal Military Training rather than to comment on whether such a program should be adopted. If the Congress, in its discretion, determines that a Universal Military Training program is necessary, the American medical profession is ready to cooperate to the fullest in its implementation. We believe, however, that we can make a contribution at this time in connection with the preliminary planning for such a program inasmuch as the various councils and departments of the Association have been studying, for some time, the factors involved in the most effective utilization of medical manpower in time of national emergency and in connection with a Universal Military Training program.

The Association has on two occasions appeared before the National Security Training Commission and discussed the medical aspects of Universal Military Training. On both occasions, our representatives and our suggestions were most graciously received. It is the belief of the American Medical Association that the Commission is deserving of commendation for the extremely fine job which it has done in studying this subject and preparing a report.

Rather than discuss all of the medical questions which arise in connection with a program of this type, I will restrict my comments to three items:

(1) *The Continuation of Pre-Professional and Professional Education for Qualified Students.*

It has always been the firm belief of the American Medical Association that should a Universal Military Training program be adopted, it is imperative that safeguards be included to prevent any disruption in the education of an adequate force of professional personnel. In order to accomplish the basic underlying purpose of Public Law 51, 82nd Congress, i.e., to provide an adequate force of well trained reserves, it is essential that the education of professional personnel be allowed to proceed without any impairment.

In its report to the Congress, dated October 29, 1951, the National Security Training Commission strongly recommended against (a) split periods of preliminary training and (b) the deferment of professional students from the six month training period. On page 28 of the report, the Commission does, however, discuss the holding in abeyance of the reserve status "of a number of medical, dental and scientific students until the completion of their professional study."

Inasmuch as this was one of the recommendations of the Association, we were pleased to see its favorable acceptance by the Commission. However, the proposal was suggested by the Commission for study only, and is not included in the legislation which is currently being considered by this Committee. With the rejection of split training periods and the deferment of professional students, it would appear that the holding of the reserve obligation in abeyance is the one remaining mechanism for insuring the uninterrupted flow of trained reserves. Therefore, the Association believes that it is imperative that this proposal be incorporated in the legislation under consideration. Such a change could be effected by adding a proviso to Sec. 9 (b) of H.R. 5904.

In this connection, two further points should be considered. The Commission's report on page 28 also notes that: "Under such an arrangement, the reserve obligation of seven and one-half years would not begin to run until *graduation from* medical, dental or scientific school" (emphasis added). It is believed that this recommendation should be changed to refer to completion of professional education rather than graduation from medical school. Such a revision would encompass the completion of internship and in some instances residency training. Such an amendment would appear to be in line with the thinking of the Commission, in view of the following statement which appears in the same paragraph as the above quoted statement: "it would also provide the armed forces with reservists who were qualified doctors, dentists and technicians, instead of mere apprentices in these fields."

In the implementation of this recommendation, it is essential that no undue advantage accrue to Armed Forces hospitals by allowing internship and residency service in such installations to count against total reserve obligation. If this were permitted, the obtaining of interns and residents by civilian hospitals would be made increasingly difficult.

The American Medical Association sincerely believes that a person eligible for induction into the National Security Training Corps, whose aptitude or previous accomplishments indicate that he can best contribute to the nation as a trained professional man, should be placed in a category that will permit him to continue his education, and that such a person be so classified before or at the time he reaches the age of induction. It is also believed that the selection of

students and the control of educational programs should remain in the hands of the individual colleges and universities.

(2) The Performance of Pre-Induction, Induction and Periodic Reserve Physical Examinations.

Neither Public Law 51, 82nd Congress, nor the report of the Commission specifies who will perform the induction and pre-induction examinations for National Security Training Corps inductees or the periodic physical examinations while they are members of the reserves. If an attempt is made to perform these examinations by using full-time medical personnel of the Armed Forces, it will be necessary to call into service a much larger number of physicians than is currently required.

It is the belief of the American Medical Association that the use of additional physicians in the Armed Forces for this purpose is undesirable and unnecessary. It is recommended instead that such examinations be conducted by civilian physicians on a fee basis or by reserve personnel, for the purpose of maintaining a satisfactory reserve status. This system is now operating successfully with respect to the conducting of periodic physical examinations for reservists in the Armed Forces.

(3) Source and Selection of Medical and Allied Professional Personnel.

The third point I would like to mention deals with the proper agency to determine the medical and allied personnel necessary to man a Universal Military Training program and the extent of the need.

There is considerable concern in the medical profession as to the manner of selecting such personnel and the proper agency to determine the extent of the need.

The American Medical Association is in favor of vesting the authority for making such decisions in a national civilian board or a comparable agency in order to insure the proper distribution of medical and other health reserves between civilian and military needs. Unless this is done, it will be extremely difficult to insure that individuals serve in a manner which will contribute the most to the strength of the nation.

There are two other extremely important medical aspects of Universal Military Training to which I would like to allude. One deals with the medical treatment to be afforded members of the National Security Training Corps and the second with the eligibility of members of the Corps for veterans' medical benefits.

With respect to the first, let me say that the American Medical Association thoroughly supports the concept that those individuals who cannot meet the physical and mental requirements established for induction into the National Security Training Corps should, when possible, be rehabilitated, but it equally strongly opposes the idea that this responsibility belongs to the Federal government.

The original version of S.1, which bill eventually became Public Law 51, 82nd Congress, contained a section providing for the assumption of corrective treatment and rehabilitative care by the Federal government. The American Medical Association feels that the deletion of this section by the Congress, prior to the enactment of S.1 into law, is indicative of congressional intent in this regard. In our conversations with the National Security Training Commission, it is apparent that they are also in agreement with us on this point.

The treatment of injuries and sickness arising during, or as a direct result of, military service while in the National Security Training Corps will, of course, be a responsibility of the government. It is believed, however, that in light of the extremely short period of service and the favorable conditions which will prevail (i.e., no overseas assignments, no combat duty, etc.) the number of doctors per 1,000 inductees should not exceed the existing requirements for the civilian population generally. Further, it is believed that whatever additional medical personnel is required should be obtained without enlarging the regular complement of the medical corps of the three services. With respect to the reserve personnel which will be recalled in this connection, it is recommended that a rotation system be adopted with short terms of active duty required.

The American Medical Association is in agreement with the recommendation of the National Security Training Commission concerning the status of trainees with respect to veterans' medical benefits.

It is our belief that the Commission deserves particular praise for its constructive comments with respect to the undesirability of adopting the present framework of veterans' legislation as a means of dealing with disabilities and deaths among such trainees. The use of Veterans Administration installations for such purposes would create a need for additional facilities and increased medical staffs, therefore adding to the growing strain upon the health and medical manpower resources of the nation created by the existing emergency.

In conclusion, I would like to express the appreciation of the American Medical Association for this opportunity to appear before your Committee and present our views on this extremely important subject. If the Association can furnish any additional information or be of assistance in any other way be assured of our willingness to cooperate.

REPORT PROGRESS IN MEDICAL EDUCATION FINANCING

CHICAGO—Problems of medical education and licensure were discussed thoroughly at the 48th annual Congress on Medical Education and Licensure in the Palmer House, February 10-12. The gathering drew nearly 500 medical educators, state board

officials and members of advisory boards in medical specialties.

Speakers reported progress in the movement to raise private funds for medical education, and confidence was expressed that hard-pressed schools will not be subjected to possible federal control by accept-accepting government aid to meet mounting instruction costs.

Dr. John W. Cline of San Francisco, president of the American Medical Association, announced a new plan which promises to be a substantial source of private funds for medical education. Dr. Cline also warned medical schools against becoming "perpetually dependent on Washington handouts."

He said that the A.M.A. Board of Trustees has approved in principle a plan whereby the association, as a corporation, would accept patents for medical discoveries made by member physicians. All royalties, he said, would be turned over to the American Medical Education Foundation for distribution to medical schools.

"The A.M.A. has appointed a committee to study the technicalities involved," he said. "Provided no legal barrier is encountered, the proposed plan shortly will become a reality."

Dr. Cline also said that in supporting one-time federal grants to medical schools for construction and renovation, the A. M. A. believes them to be reasonably free from the hazard of federal control.

An increase in medical school enrollment of students from small towns probably would result in a larger supply of doctors in such areas, according to Dr. H. G. Weiskotten of Skaneateles, N. Y., chairman of the A. M. A. Council on Medical Education and Hospitals. A recent study of the present location of physicians who graduated from medical schools in 1930, 1935 and 1940 showed that residence before admission to medical college is in general the most potent factor in determining the place of practice, Dr. Weiskotten said.

Contributions to the American Medical Education Foundation are gaining in momentum, it was reported by Dr. Donald G. Anderson of Chicago, secretary-treasurer of the foundation and secretary of the council. During 1951, contributions totaling \$745,000 were received from 1,811 individual physicians, 33 organizations and 33 lay friends of the medical profession, Dr. Anderson said.

"It is hoped that by concentrating fund raising activities in the spring of this year, the foundation will have a substantial sum available to turn over to the National Fund for Medical Education for distribution to medical schools on or about July 1," he added.

Dr. Anderson also said that under a recently adopted policy, contributions by doctors who specify a particular medical school will be added to that school's full share from the un earmarked funds raised by the foundation and the national fund.

Plans for an international conference on medical education were announced by Dr. Louis H. Bauer of Hempstead, N. Y., secretary-general of the World Medical Association and president-elect of the A.M.A. The meeting will be held in London, August 24-29, 1953 (correct). The aim will be (1) an exchange of ideas; (2) a possible unification of thought; (3) aid to underdeveloped countries.

"We feel that this will be one of the most important events in medical history," Dr. Bauer said.

Eleven states in the south last year contributed \$1,091,500 to a common fund for medical education, it was reported by William J. McGlothlin of Atlanta, consultant for professional programs, Board of Control for Southern Regional Education. The participating states are Alabama, Florida, Georgia, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, Texas and Virginia.

The schools in the medical program are: Duke University, Durham, N. C., Emory University, Atlanta; Louisiana State University and Tulane University, New Orleans; Medical College of Alabama, Birmingham; Vanderbilt University and Meharry Medical College, Nashville, and University of Tennessee, Memphis.

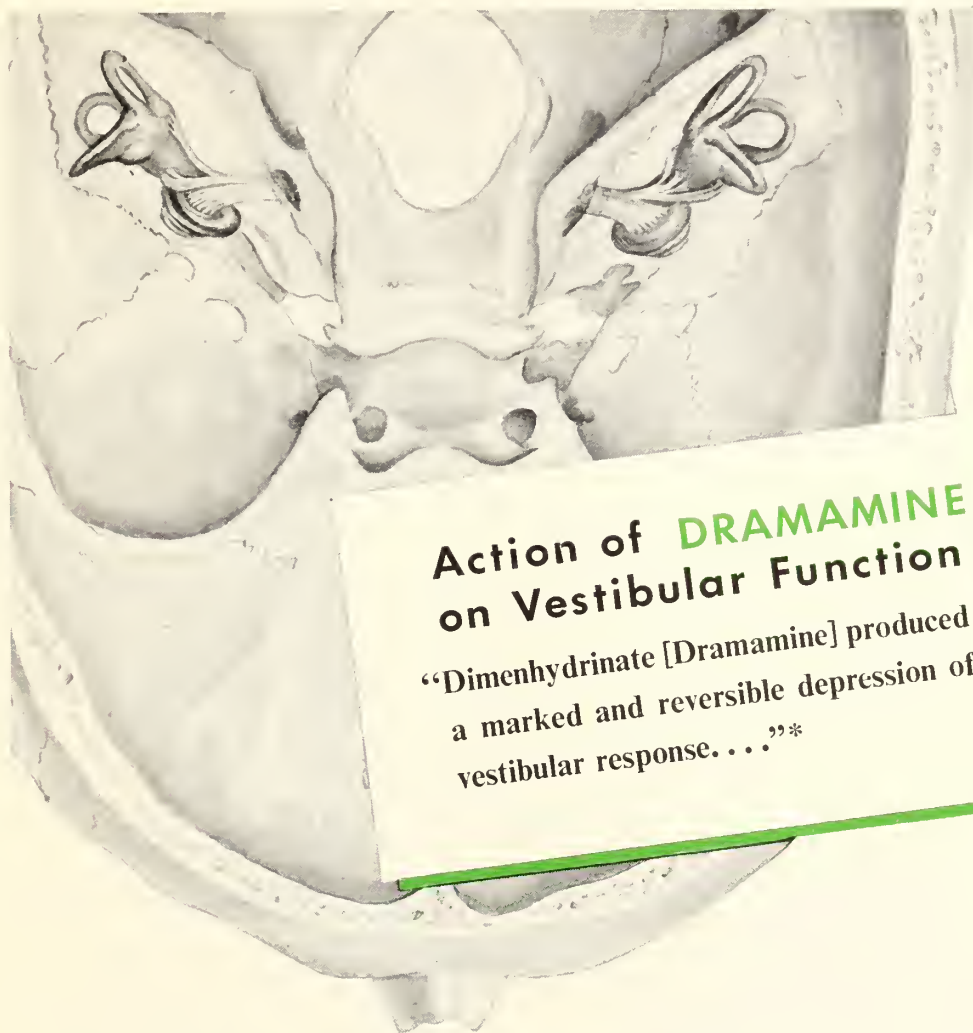
A somewhat similar program is being worked out to cover 11 western states and two territories, it was announced by Dr. Ward Darley of Denver, vice-president of the University of Colorado and dean of its department of medicine. Legislatures of five states—Colorado, Montana, New Mexico, Utah and Oregon have approved the plan, clearing the way for activation. Other states involved are Arizona, California, Idaho, Nevada, Washington and Wyoming, and the territories of Alaska and Hawaii. The program is expected to be in full swing by the fall of 1953.

Medical schools should insist that research grants bear the full cost of the studies undertaken, in the opinion of Laird Bell of Chicago, chairman of the board of trustees of the University of Chicago and a member of the Commission on Financing Higher Education. A study by the commission indicated that if medical schools and their universities received the full overhead costs of federally-sponsored research, they would receive more than \$6,000,000 in additional income.

"Instead of asking the federal government for new legislation and new funds, why not ask the federal government to appropriate and pay the full costs of the research it already promotes?" Mr. Bell suggested.

He also said the commission was unanimously opposed to Senate Bill 337, providing for government subsidy of instructional costs, adding that if he were a dictator intent on getting control of the medical profession he would begin at the school level.

There has been a significant increase in the number of American students going abroad for medical training, according to Dr. Francis R. Manlove of Chicago,



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*Gutner, L. B.; Gould, W. J., and Batterman, R. D.: Action of Dimenhydrinate (Dramamine) and Other Drugs on Vestibular Function, Arch. Otolaryng. 53:308 (March) 1951.

RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

associate secretary of the A.M.A. Council on Medical Education and Hospitals. Dr. Manlove emphasized, however, that American schools are accepting a much larger proportion of applicants than is generally appreciated.

Fifty foreign medical schools, he said, reported an enrollment of 671 American students. Switzerland had the largest number with a total of 363. The Netherlands was second with 67. Only 17 were enrolled in British schools.

American corporations are joining the medical profession in providing funds for medical schools, it was reported by Chase Mellen, Jr. of New York, executive director of the National Fund for Medical Education. Contributions last year from all sources totaled \$1,799,188, including \$745,917 from the American Medical Education Foundation. Unrestricted grants of \$1,594,373 have been made to schools.

Basic research in science will be given an \$8,500,000 federal assist over the next year if Congress should vote the requested \$15,000,000 appropriation for the National Science Foundation for the 1953 fiscal year, it was announced by Alan T. Waterman,

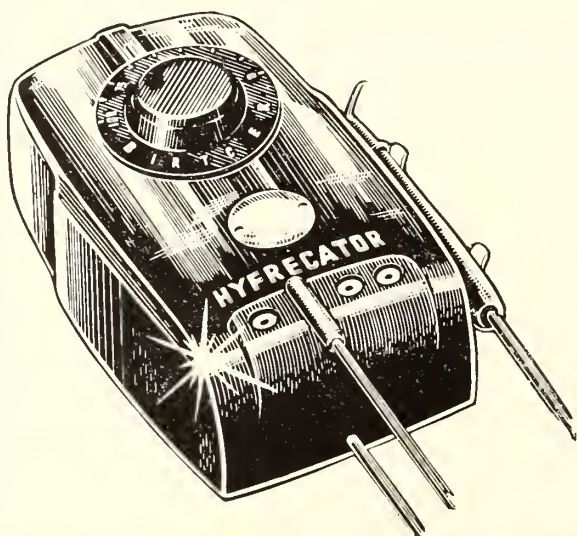
Ph.D., of Washington, director of the agency. In the medical sciences, grants are being awarded for basic studies rather than in clinical medicine, Dr. Waterman said.

The development of television soon may bring sweeping changes in the techniques of keeping doctors informed of medical progress, in the opinion of Dr. George N. Aagaard of Dallas, dean of the Southwestern Medical School of the University of Texas. Dr. Franklin D. Murphy of Lawrence, Kan., chancellor of the University of Kansas, discussed the obligations of the modern medical school.

The three-day meeting also dealt with standards for the approval of residency training programs, the problems of state boards in interstate endorsement and reciprocity, the place of preceptorships in undergraduate medical education and problems of internship and residency as related to medical licensure.

The congress was sponsored by the Council on Medical Education and Hospitals of the A.M.A., the Advisory Board for Medical Specialties and the Federation of State Medical Boards of the United States.

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TEN POINT PROGRAM OF THE SOUTH CAROLINA MEDICAL ASSOCIATION

1. Cooperation

To promote closer cooperation and better understanding between all agencies, groups and individuals concerned with providing and improving medical care for the people of South Carolina.

2. Extension of Medical Care

To study constantly the need and availability of medical care in each county of the State and in the State at large.

To promote plans for providing or improving medical care where is a need, particularly in the rural areas.

3. Pre-Paid Hospital and Medical Care

To make voluntary pre-paid hospital and sickness insurance available to all the people of the State (through Blue Cross, Blue Shield, and commercial insurance policies), and to promote the widespread purchase of such insurance.

4. Care of Indigent

To work with local county and state agencies, and with philanthropic organizations, toward securing good medical care for the indigent.

5. Public Health

To support the South Carolina State Board of Health in its broad program of preventing diseases and of safeguarding the health of our people.

6. Health Councils

To support the State Health Council in its announced program. To sponsor

the formation of a County Health Council in every county of the state, and to encourage our members to support and to work with these organizations.

7. Hospitals

To promote the expansion of present hospital facilities and the building of new hospitals—where there is a definite need.

To strive for highest standards of professional care in the hospitals in the State.

8. Medical Colleges

To support the Medical College of the State of South Carolina and to bend our efforts toward keeping its standards of education on a par with other medical colleges throughout the country.

To promote good nursing education and good nursing care throughout the State.

9. Education of the Public

To acquaint the citizens of the State with regard to the problems of medical care in existence today, to inform them as to what is being done to solve these problems, and to advise with them as to further plans for securing better health and better medical care for the people of South Carolina.

10. Political Medicine

To prevent political control or domination of medical practice or of medical education.

WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. K. D. Shealy, Columbia, S. C.

Publicity Secretary: Mrs. Weston Cook, Columbia, S. C.

WOMAN'S AUXILIARY TO THE AMERICAN MEDICAL ASSOCIATION

Suggestions from the National Program Committee—1951-1952

Mrs. Alfred F. Burnside, of Columbia, S. C.

1. Promote friendliness and fellowship among physicians' wives and families and the lay public.
2. Plan your program on a yearly basis and have them approved by your Advisory Council.
3. Use the Auxiliary Pledge of Loyalty at your State and County meetings.
4. Consult your Advisory Council concerning the most urgent health problems in your community; adopt and promote those health projects most suited to the needs of your area.
5. Do not use the insignia of other organizations.
6. Be careful in your selection of speakers and be sure they are not adverse to the principles of the Auxiliary.
7. Obtain speakers trained in the field of the health project undertaken by your Auxiliary.
8. Maintain a Speakers Bureau on a State and County level and offer its services to other organizations, thus fostering good will and promoting public education.
9. Plan some meetings relating to health and health education.
10. Make your programs short, interesting, and varied. They will conform to the times and increase attendance.
11. Plan a social hour if possible. Acquaintance makes better working relations.
12. Conduct a School of Instruction or maintain a Committee of Instruction in order to inform all members as well as officer personnel of the object, duties, and responsibilities of an Auxiliary member.
13. Know the Association to which you are an Auxiliary and you will render better service. Do the type and quality of work that will make your Medical Societies recognize you.
14. Cooperate with your State and County Medical Societies. Make your programs conform to theirs at Conventions.
15. Read the National Auxiliary Bulletin, Exchange Auxiliary Publications, the Auxiliary pages in the A. M. A. Journal, State and County Medical Journals, National and State Newsletters.
16. Answer all correspondence promptly. Send in your program outlines to your Regional Program Chairman or National Program Chairman in time for your State and County reports to be included in the national reports.
17. Keep a file of program material for your successor.
18. Take advantage of the program material available from the A.M.A. and the Auxiliary Central Office.

WORKING TOGETHER FOR HEALTH

by Mrs. Harold F. Wahlquist
President, National Auxiliary

As the wife of a physician our first extra curricular interest (we all keep house) is health. Besides having projects in our own organization to promote health, most of us are members of other community groups, making efforts to be leaders in health.

Part of a girl's responsibility as a doctor's wife is to adjust her own interests and activities to her husband's work. Many of us are not trained health leaders—it is a responsibility we acquire with a husband. We're surrounded with matters pertaining to health and problems relating to it—morning, noon and night. We soon live it and learn it.

There are 57,000 members of the Woman's Auxiliary. When we begin one of our projects for health, I always think of that number and it encourages me. Sometimes I remind our units that—one woman can be helpful, one hundred women can be forceful, one thousand women can be powerful, ten thousand women can be invincible.

Educating the people to available facilities and how to use them is our chief concern. Our job is to help people to help themselves in true American fashion. It isn't that people don't want responsibilities—often they just do not recognize them. Health is everybody's job.

Active progress demands that we follow the theme we have adopted for this year "working together for health."

At the February meeting of the Greenville Medical Auxiliary, Mrs. John M. Holmes, first vice-president of Greenville League of Women Voters, emphasized the importance of the acceptance by the women of their responsibility in civil government. According to Mrs. Holmes, the League is a channel of information on national, state, and local affairs and offers an excellent route whereby the individual can do something about the existing or impending situations which we too often look at, complain about, and feel helpless to act upon.

When the Auxiliary meets in March, a panel discussion on mental health will be the theme. Expected to participate are several members of the staff of the local mental hygiene clinic who will describe the status of this clinic in our community and state. Mesdames Steele Dendy, Mills Goodlett, and Charles Wyatt will serve as hostesses.

Mrs. John Robinson, chairman of the maternity shelter project, reports that auxiliary members continue to give two hours per day to the care of infants at the clinic. Recently auxiliary members have contributed to the clinic a high chair, an assortment of toys and a Christmas tree.

It is with deep sorrow and regret that the members of the Auxiliary to the Greenville County Medical Society record the passing of one of their beloved members, Mrs. Lucia Gaines Shirley.

Mrs. Shirley was born May 31, 1869, and died December 21, 1951. She was the wife of Dr. L. T. Shirley, who practiced medicine in Central, South Carolina, for a number of years, and passed away in 1917.

South Carolina Medical Association

1951-1952

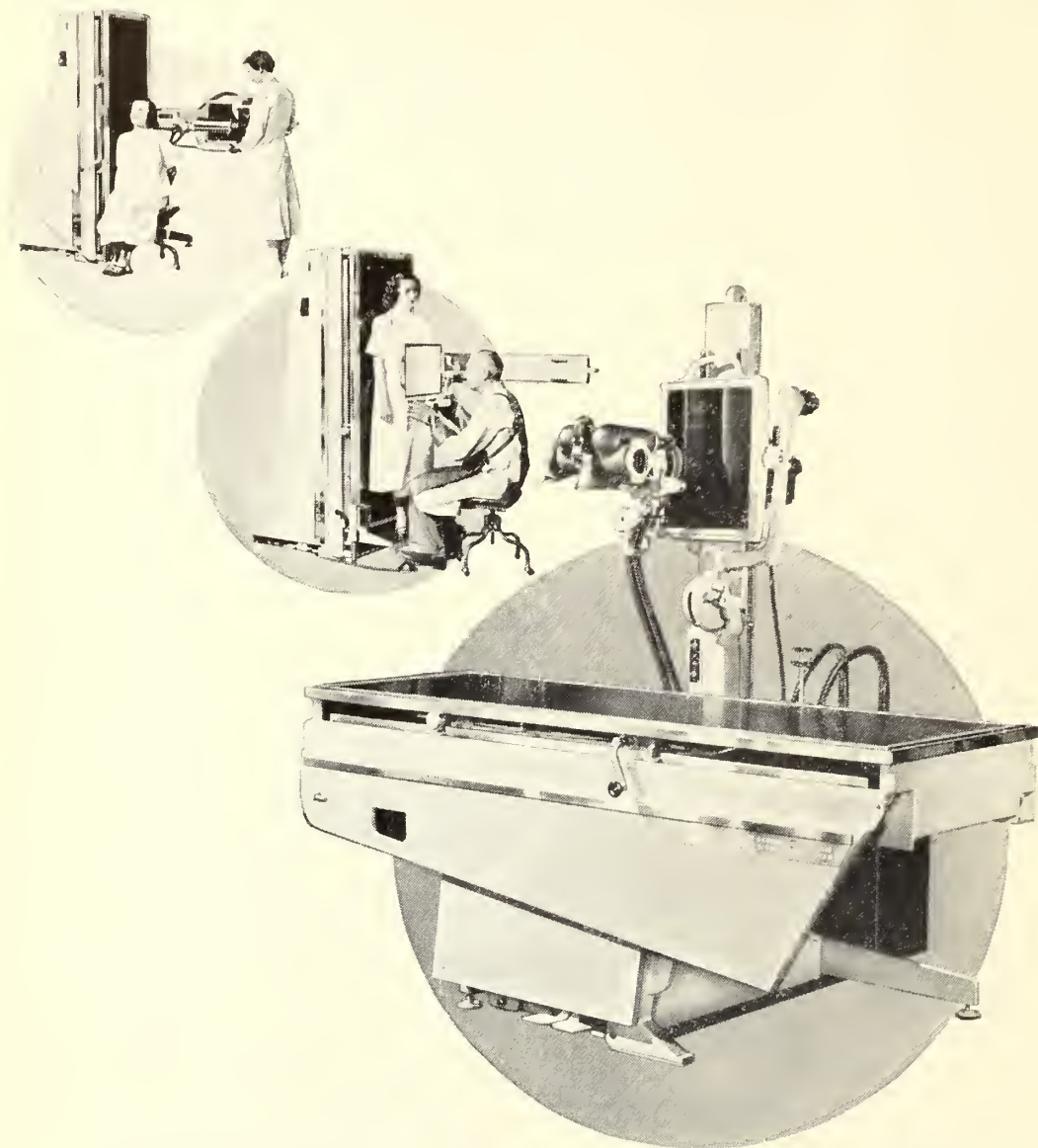
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The Emotional Aspects of Pregnancy

KENNETH G. LAWRENCE, M. D.
Florence, S. C.

The purpose of this presentation is to direct attention to the emotional aspects of pregnancy, which form an important part of every day obstetrical practice. Much progress has been made in the last twenty years towards increasing the margin of safety in motherhood. Guess¹ has recently reported the rapid strides being made in the reduction of maternal mortality in South Carolina during the last decade. Accompanying this progress in the physical welfare of their patients, physicians are now showing an increased interest in the emotional factors, which contribute to the good health of their patients. As physicians we have unusual opportunities to direct patients in healthy attitudes regarding sex, marriage, childbirth and parenthood.

The human being is constantly making progressive adaptations to life with psychobiologic failures under stress and finding methods that can be employed to relieve such failures. Childbearing may confront the mother with many serious problems in psychobiologic adaptation and these should be evaluated with the physiologic and pathologic processes of pregnancy.

The personality and its development is an important consideration. "During the first year of life the infant necessarily exists in a state of complete dependence on those concerned with its care. As the child grows, inevitable frustrations and responsibilities are met, and it may develop deep-seated fears, distrusts and hostilities. Later, the adolescent must adjust to sexual and other social problems, which necessitates many self-imposed inhibitions and increasingly complex interpersonal adjustments that eventually determine his adult character. Generally, a healthy child raised by loving and understanding parents grows into a self-reliant, emancipated, and socially responsible adult. However, if the child's development is handicapped by physical diseases, or distorted by parental neglect, abuse of other adverse childhood experiences, it may develop into an unconsciously insecure, oversensitive, anxiety-ridden individual. Under further emotional or physical stress such an individual may then revert to childhood patterns of dependency, aggressivity, and social inadaptability of neurotic character. It may develop more complex and continuous disturbances of behavior as neurosis or psychosis. Any of the clinical

varieties of these disorders may appear in obstetric practice."

Parental guidance and home environment, therefore, have an exceedingly important influence on the personality development of the maternity patient. There are the emotionally immature, who have had prolonged indulgence and protection by unwise parents, resulting in an incapacity to face realities, to make decisions, or evaluate personal responsibilities. They make poor mental adjustments to the unsatisfactory situations of life, and have poor endurance and make negligible personal sacrifices. In contrast are the mentally mature who face the problems of life unafraid. They are emotionally firmly anchored and meet and solve the issues squarely. Adaptations to joy and sorrow, wealth or poverty, disappointments and accomplishments, and the pain and anxieties of illness are made on an even keel. Understanding these basic psychologic fundamentals will aid the obstetrician in the approach to and alleviation of the maternity patient's fears.²

The personality is a composite of the patient's biologic make-up, external environment, and life history. Anything that would upset the balance between them would result in emotional responses commensurate with the change in pattern. Pregnancy is accompanied by great physiologic alterations in the biologic make-up and many mental stresses arise. Fortunately, the majority of women withstand these experiences well, but some few become emotionally ill.

The acceptance of motherhood is determined by past experiences at an impressionable age. Emotional reactions to pregnancy are a joy and pleasure to the patient who identified herself with a mother, who looked forward with anticipation to a gratifying gestation. However, if the expectant mother's childhood memories of her mother's pregnancies were an emotional threat, then her own pregnancy may be characterized by fear, suspicion or resentment.

Various mental and emotional conflicts arise out of the dominant basic feminine instinct of reproduction. In those women who do not accept motherhood, there must be a subconscious reason.³ The woman may fear she may lose her physical attractiveness or sexual

attraction or function. She may fear that this will affect her husband's affection for her both during and following the pregnancy. There is the fear in the elderly primigravida that many complications may arise, which cannot be treated properly. This is particularly important in women over 35 years of age. There is also the conflict of nursing their offspring, which may mar their physical appearance and require valuable time that they could otherwise spend on social engagements or for other economical reasons in the family. There may arise the conflict from the possibility of having mentally or physically defective children. This may be of particular importance, but often exaggerated in families where there is some hereditary tendency towards these abnormalities. There are emotional reactions, which may arise from instances involving more personal sacrifices, both socially, economically and physically, during a gestation. One can readily see how these mental conflicts during a pregnancy, which is not well accepted, may result in emotional reactions to the maternal instinct. As stated above, the emotional, mature woman will withstand these conflicts well and make a good adjustment to them. Conversely, the emotionally immature woman will develop any one of the diversified reactions, which will make the pregnancy more difficult for both the patient and the obstetrician.

Mating is an important aspect of pregnancy and the improper selection of the marital partner may result in many of the emotional ills during pregnancy. It is well to have two individuals who are essentially alike, both physically, mentally and emotionally. If there is an imbalance in these qualities, accompanied by economic inequalities and differences in religion, it may have a very definite affect on pregnancy. The physically compatible, emotionally adjusted and economically secure couple presents few problems in marriage, in reproduction or parenthood. Many of the emotional patterns and social attitudes acquired in unmarried life cause crucial disturbances when carried over into matrimony.

Emotional reactions during gestation may be variable as to whether the pregnancy is wanted or unwanted. Pregnancies as a result of planning and in which the fondest hopes of a woman have been fulfilled and the act of reproduction achieved; to her life is a blessing and a joy. The attitudes have been wholesome and the fears have been negligible. Where the pregnancy is unplanned or rejected, various degrees of emotional reaction results. Rejections, frustrations and anxieties are common. In the rejected pregnancies, the emotional responses may be so strong as to lead into severe physical impairments and emotional disturbances that may lead to acts of violence, abortion, or even suicide.

Illegitimate pregnancies may produce emotional reactions which should be considered. These are variable as to circumstances of age, location, as within the family household, organizations, as schools of learning,

or in the older career type of women. The reactions, under any circumstances, may be one of acceptance, rejection or denial. In the first, personal sacrifice is only for the welfare of their infants, and these mothers will suffer the consequences of the moral law for the well-being of their motherhood. In those patients of the type where rejection is the emotional pattern, the woman will go at no ends to interrupt the pregnancy, including her own life. In the latter type of denial, to them the pregnancy never existed.

It is still a matter of conjecture today that emotions have some part to play in sterility. However, we see, from day to day, the effect that adoption has on some couples who have been sterile for several years. It is not uncommon to see them with one or more children, following adoptions. Similarly, we have seen the effects of a change in life situations which would break down some emotional barrier to pregnancy and result in a conception. Such an example would be a business executive under constant drive and mental strain taking a long vacation or Caribbean cruise. Instances of psychologically prepared patients for pregnancy have resulted in parenthood, in couples who have otherwise been sterile. We have seen good therapeutic results for the infertile patient following a thorough physical examination and a word of assurance regarding the complete normality of the genital organs. The use of mild hypnotic, relaxing and antispasmodic drugs have often been resorted to and are beneficial to the sterile patient.

Pseudocyesis⁴ should be mentioned as a psychic reaction that may present the most variable reactions that we find in the practice of obstetrics. It may occur at any age from 7-80, but more frequently in the child-bearing age. The etiological factors are a wish for a pregnancy or a fear of pregnancy. There is some strong biologic, sociologic or economic need for a pregnancy, and physically the body adjusts to this need. Similarly, a fear of pregnancy may, under certain conditions, produce the same emotional reaction.

Emotional responses to pregnancy may be influenced by certain fears. The fear of complications that may arise during or following pregnancy, and the fear of death, are frequent causes of mental unrest. Various superstitions still exist as to "marking" the unborn child by such experiences as seeing or being frightened by reptiles, witnessing some accident, an event occurring at some particular time, or unreasonable cravings for certain types of food. Very often there arises the fear of the effect of threatened abortion on the development of the offspring. The results of some of these may be real and yet some unfounded. Some of the fears are reasonable, as to the transference of some venereal disease to the offspring, or the effects of some virus disease on the normal development of the unborn child. There, naturally, exists the fear of pregnancy accompanying some preexisting disease as tuberculosis, diabetes or

cardiac impairment. Of more recent date are the fears originating from the Rh factor, and the possibilities of producing a normal pregnancy, if there is Rh incompatibility in blood between the marital partners. The fear of anesthetics and which is to be preferred in each selected case, produces various emotional responses that the obstetrician can readily alleviate. The articles in women's magazines many times do not explain the various conditions to the patient's understanding and kindles the fears that until that time may have existed only quiescently.

The mother-child relation is an important emotional aspect. During the nine months of gestation the child is an integral part of the mother. If the mother is allowed to handle the baby frequently shortly after birth, the transition between intrauterine and extrauterine life is less marked. It also allows the mother to become more intimately related with the child in this new capacity. There is an emotional bond of love in mother-child relationships. If the mother has confidence that her love and the things that she does for her baby are the best that the baby can have, then there is a mutual understanding of love. Not to be forgotten is the father. The mother's emotional reactions to the child are influenced greatly by her relation with her husband. The child's arrival creates the family triangle and this new situation requires that the marital partners readjust the emotional equilibrium to which they have become accustomed.²

In obstetrical care the physician should have complete confidence of his clientele. He should be the therapist for her ills during gestation, the accoucher at the time of delivery, and always the bulwark against her fears.⁵ The mother should be left with the feeling that she has done well and that she is ready to have another at a later date.

In closing, I would like to quote from Park's address before the South Atlantic Association of Obstetricians and Gynecologists. "In obstetric care the patient's psychic reserve is as important as her physical capacity. Symptoms of nausea and vomiting, multiple vague complaints, compulsive appetite, demands for complete narcosis, revulsion at suggestion of breast feedings, sleeplessness and morbid interest in details of pregnancy usually suggest degrees of rejection to the role of motherhood. Recognized early these symptoms permit time for turning the patient's thoughts to a more positive and pleasant attitude.

Many of the circumstances which make pregnancy and childbirth difficult can be corrected through language. By talking good health we can prevent

much ill health. We have all witnessed the mental anguish of the patient who has been told that she should not conceive, or that she should not have another baby. In these days of modern medicine and surgery there are very few indications for a physician to try and limit a family verbally. Another unpleasant conditioning process is our tendency as gynecologists and obstetricians to compare pelvic tumors with the size of a pregnancy of 7 month's duration. This is particularly disturbing to the infertile patient and to the maiden lady. A prospective mother is not encouraged by the unpleasant knowledge that her pelvis is so contracted that it will not permit the passage of an object of a certain diameter, let us say a fair sized orange. The mental scars of an unpleasant pregnancy persists long after the episiotomy has healed.

While we must maintain a diligent respect for the serious complications which can occur in pregnancy, it is our duty, responsibility and pleasure as physicians to convey a feeling of security, happiness and well-being as free from all fears as possible, in the new mother-to-be. Fertility alone indicates some degree of help. A healthy pregnancy can be used as a growth producing, beautifying physiological process with a goal objective. In no other field of medicine does a physician deliver such a prize possession as a newborn infant.

It will take such time and thought to establish such substitutes for such words as "labor pains," and "rupture of the membranes." We can talk about contractions rather than pains, about first stage lying-in rooms rather than labor rooms, about drainage or letting off fluid, rather than rupture of the membranes. But of greater possible importance is general adoption among the medical and nursing profession of less frightening, wholesome attitude toward the complete process of pregnancy, childbirth and parenthood."⁵

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Basic Facts Concerning Suicide

By

ORIN ROSS YOST, M. D., Psychiatrist-in-Chief
Edgewood Sanitarium Foundation, Orangeburg, S. C.

Since the earliest days of recorded history the phenomenon of suicide has not ceased to baffle mankind. Though studies of suicide have been inadequate and authentic records are incomplete and comparatively few in number, this act of voluntary and intentional self-destruction challenges the best efforts of sociologists, physicians and psychologists today, for suicide continues to be a menacing social problem both national and international in scope.

The pages of Holy Writ record numerous instances of suicide, and chronicles dating back to earliest recorded history reveal significant data pertaining to both the method and the man. It was not, however, until two hundred fifty years ago that the term "suicide" (from two Latin words, *sui* meaning *one-self*, and *caedo* meaning kill) came into use. Throughout the centuries this voluntary act of killing has evolved through various stages and connotations with the result that even today its status is still misunderstood. In some sections of the world this act is demanded and condoned among primitive tribes, whereas in other sections even the attempt to suicide is punishable by imprisonment or possible confiscation of property. In other countries, as in the United States, for example, only four states regard attempted suicide as a criminal act.

Clarification of numerous aspects of this subject will entail a profounder research, but this paper will attempt to set forth a few valuable findings and to note a few existing fallacies.

Incidence of Suicide Today

At present the ratio between suicide and homicide is two to one, respectively. Though this average obtains, it is also noted that in areas where a low rate of suicide is found, the rate of capital crime rises appreciably, as is seen in the islands of Corsica and Sicily, for example.

Though suicide constitutes one of the major causes of death, and though its incidence is equivalent to the combined incidence of five of our most common communicable diseases, it nevertheless represents a wide fluctuation with the passing of the years. Generally speaking, its incidence has decreased during times of war and prosperity and increased during economic depressions and great national shifts or movements in which personal adjustment proves difficult as, for instance, the after-math of war or stressful transitions of religious movements.

Statistics of reliable life insurance companies reveal

the fluctuation in the United States (based on one suicide out of each 100,000 inhabitants) as 16.0, 11.9, and 13.6 during 1910, 1922 and 1930, respectively. In the year 1932, the peak year, when the world-wide economic depression was at its bottom, the ratio stood at 17.4 while in France it reached 20.6 and in Germany, 29.2. It has been estimated that in 1933, throughout the world 310,000 suicides were recorded. This figure represents an excess of 6,000 deaths over the total dead and missing of the United States Armed Forces for the duration of World War II. In 1937, in this country the incidence stood at 14.9 for every 100,000 population.

Areas in which the lowest death rates obtain include Eire, Northern Ireland, Scotland, Norway, Italy Bulgaria, Lithuania, Spain, Canada and the Netherlands. Throughout the past four decades, the highest ratios have obtained in Germany and France. At the present time within the United States suicides in hospitals and within the communities themselves account for one-half as many fatalities as do motor vehicle accidents. In New York City alone it is estimated that six suicides take place during every twenty-four hour period. What with these deplorable statistics, it can be readily seen that suicide is a universal phenomenon, a baffling social and economic problem which continues daily to disrupt community and family life.

Etiology of Suicide

Why do people suicide? Not to everyone is life so beautiful that the world cannot, in the words of Edna St. Vincent Millay, "be held close enough." Many there are who are continually obsessed with the desire to terminate their earthly existence and thus make a final regression from all reality.

It is believed that to practically everyone, normal and abnormal, suicidal ruminations come at some time in life. By some these meditations are easily cast aside; by others they are impulsively translated into action—successful or unsuccessful; and by still others they become an obsessive passion in a struggle for non-existence.

The writer has previously referred to suicide among primitive tribes. In spite of the belief that the lower the cultural scale, the lower the incidence of suicide, it is true that numerous suicides have continued to occur among primitive peoples because of the prevalence of gross superstitions and adherence to ritualistic customs. For instance, fanaticism in religious practice in India once decreed the burning

of Hindu widows on the funeral pyre of the departed mate. As a means of escape many widows resorted to suicide. Among Central American Negroes, death by poison is frequently resorted to by an innocent survivor who fears being accused of responsibility for the death of her mate. Many despised, penniless prostitutes in Mexico also turn in despair to suicide. By ripping open their bowels many Japanese formerly turned to self-destruction through *hara kiri*. Oftentimes savages wishing to avoid capture or suffer torturing indignities have resorted to death at their own hands. Rather than submit to forced marriage with undesirable, impotent old men, the females among the South-African Negroids frequently resort to hanging themselves.

Aside from those who were moved to suicide because of religious beliefs or superstition, many there were in the pre-Christian era who entertained philosophical attitudes in which suicide was condoned. Sages including Seneca, Cato, Zeno, and thousands of others contended that the mode of death was a matter of personal choice and thus selected suicide. Later, with the acceptance of Christianity, nations developed different conceptions of life and death; and gradually the church was instrumental in effecting a decline in self-destruction of man's body, the temple of the Holy Spirit.

It should also be noted that during the early days of recorded history, often at the command of a king, emperor, or other ruling authority, many subjects submitted to death at their own hands. Throughout all time many imbeciles, it should be noted, have brought destruction upon themselves, oftentimes accidentally.

In addition to the etiological factors of suicide named above, it should be noted that several innovations have caused researchers to view the universal problem of suicide in a more satisfactory manner. The innovations herein referred to have been made possible by the role assumed by both church and state as each concerned itself with this perplexing menace, also by the unparalleled advance occasioned by scientific investigation, particularly in the fields of psychiatry and psychopathology.

In further enumerating the etiological factors of suicide, the writer would remind that in some areas twice as many suicides occur as are actually reported, such failure to report being due to an attempt on the part of the physician to cover up the act. He would also remind that all so-called suicides are not genuine, some having been intended for attempts only, but accidentally proving successful.

Mental disorders are frequently the cause of suicide. The act of self-destruction is reported among patients having all types of mental diseases, organic and functional. Those disorders in which the highest incidence of suicide occurs, however, are the depressive psychoses and the schizophrenias. Though some

authorities hold that psychoneurotics do not suicide, this generalization is not accepted by others. Oftentimes the psychoneurotic develops a depressive psychosis on the background of his psychoneurosis and resorts in some instances to suicide.

In patients having involutional melancholia, the suicidal symptoms are very severe until convalescence has begun, but once having begun, it is followed by a rapid recovery with small likelihood of relapse. Melancholia, it might be said, is undoubtedly the most important factor in causing suicide, the act itself being frequently committed during the period of depression in cyclic mental illness. Probably more than one-third of the cases of suicide are traceable to this form of mental condition. Suicides often take place during the depression stage following drunkenness, also during symptomatic depression observed in general paresis, neurasthenia, hypochondriasis and epidemic encephalitis.

Any form of mental confusion such as acute delirium, pellagra, delirium tremens, or cerebral tumors may lead to suicide.

A tendency toward suicide is found sometimes in families. In the unconscious of the offspring of a suicide there seems to exist a feeling of guilt; and hence at approximately the same age at which a parent committed suicide, one or more of the offspring for successive generations may follow the suicidal pattern.

Suicides have been known to result from the loss of a loved member of the family, sexual abnormalities, feelings of inferiority, disappointment, jealousy, revenge, loneliness, disgust over menstruation, miscarried ambitions, physical illness, financial losses, discontent over occupations, phases of the moon, military service, distasteful climate, domestic strife, unwanted pregnancies, thwarted love affairs, nostalgia, power of suggestion and the fear of discovery of some actions inconsequential in themselves but serving as a burden to the mind.

A large number of these causes for suicide will be recognized as precipitating ones only. When people appear to turn to suicide because of frustrated ambitions, financial disabilities and similar causes, scientists entertain no doubt as to the existence of a deeper underlying cause. Every suicide has a motive. The eminent Emil Kraepelin has estimated that 33 per cent of the suicides were psychotic. Esquirol also believed that suicide was attributed to a special form of mental disease. Today, however, during this psychotherapeutic age, neither statistics nor experience supports the belief that suicide is evidence of mental derangement. The oft-repeated verdict that an individual suicided "while temporarily insane" is traceable to a gesture of kind consideration for the family who prefer the stigma of temporary mental derangement to that of self-destruction.

The fact that an impulse to suicide is a conspicuous

symptom among many who are mentally disordered furnishes no conclusive proof that all who suicide or attempt suicide are abnormal. The large majority of suicides, in fact, are not certifiable as mentally diseased, and law holds every man sane until he can be proved to the contrary. In England the term *suicide* is used with reference to the act when it is committed only while the deceased was of unsound mind. Otherwise the same act is known as *felo de se*; and because such an act implies commission while the individual was of sound mind, penalties are exacted against the estate of the deceased.

In view of the finding that many of the causal factors of suicide are only precipitating, and in view of the danger that suicide is ever present in some mental disorders, to what one might ask, is genuine suicide actually attributable?

Dr. G. R. Jameison contends that the psychosis does not represent the actual suicide drive, for suicide represents one's failure to handle conflicts between the conscious social adaptation and the unconscious asocial strivings. Jameison considers the motives for suicide on the basis of infantile organization as a very important factor. He stresses the importance of studying the ingrained nature of a person to determine whether he early showed a tendency to passivity or aggressiveness. Often during growth the inherent disposition is covered over, and early tendencies or adolescent ones of the child are later given free rein when the patient becomes psychotic. It is often seen that in some personalities there seems to be a predisposition to return to psychologic levels of immaturity. Thus it can be seen that a glance into the childhood history of suicidal patients reveals the fact that many have experienced difficulty in dealing with hostile impulses and aggressiveness. Many likewise have experienced feelings of guilt and the need for punishment. It is interesting to note that when the latter type make suicidal attempts which are detected in time, the patients suddenly begin to improve, the depression seeming to have lifted itself abruptly. Perhaps this condition prevails because the patient realizes that his guilt has been expiated through his attempted suffering.

Besides these types of individuals in whose personalities there are recognized specific infantile and preadolescent tendencies, it has been noted that others who show suicidal tendencies are people with temperaments characterized by day-dreaming and by idealism, also those who mature somewhat late and are backward in their development as well, as those who tend toward self depreciation and self abasement. To this category might also be added the unbeliever and the atheist, neither of whom entertains any dread of a future life.

Post mortem examinations and psychosurgery have revealed the fact that anomalies in the skull (such as irregularities of the surfaces, greater sharpness of

ridges and angles, overgrowth of lymphoid tissue of the thymus, an over-sized brain and so on) are more often detected in cases of suicide than in normal people who do not attempt suicide.

In an effort to explain the etiology of suicide, the writer has set forth some important findings but maintains that probably the basic cause of suicide is still unknown. He is prone to believe, however, in the words of Morselli that "... the progressive increase of suicide is not possible to explain otherwise than as the effect of the universal and complex influences to which we give the name civilization." Suicide has been defined thus as a "failure in adjustment at this high level of adaptation." It represents a denial and shirking of the duty of the individual as an integral part of the universal whole.

It is believed that the suicide belongs to a definite type of personality not necessarily psychotic but potentially so.

Types of Suicides

Because so-called suicide occurs in various settings and represents various types, it will be well to consider special categories.

First of all might be mentioned the *malignant* suicide. This type is found among those individuals who are typically melancholic and who, once having made an unsuccessful attempt at self-destruction, must thereafter be considered suicidal risks and furnished with proper supervision. Ideas of self-destruction grow progressively more insistent to the patient who contemplates suicide as the only solution to an intolerable situation. If one attempt fails, the patient is almost sure to follow it with further attempts, for so intent is his purpose of suiciding that every moment he continues to contemplate the act and to concentrate upon it with "gun-barrel mental vision." Regardless of his past interests, he now appears oblivious of everything except his solitary, overwhelming intention to terminate life and to make a final retreat from the vicissitudes of living. In the event that he is frustrated in his attempt, he is likely to vent his wrath upon the frustrator, to express great disappointment, to grow more irritable, even violent, assaultive, homicidal, and finally amnesic in some cases. Those patients who later recover admit that the intensity and the urgency to suicide which had formerly tortured them is practically inconceivable to the normal mind.

Such malignant types of suicide are of course dangerous to themselves and to the community and hence demand constant, alert supervision. Even in the best institutions "accidents" occur occasionally, regardless of the excellent supervision; and a patient may injure himself seriously or even destroy himself. Dr. Jameison stresses the fact that it is impossible to restrict completely every person about whom the authorities entertain a suspicion of suicide. Nor indeed

would total restriction be wise, for it would then be impossible to give institutionalized patients the maximum treatment due them. The eminent psychiatrist, Clarence B. Farrar says:

"Constant supervision in the case of such a patient self-evidently means every second of every minute of every hour in the twenty-four. Even then the issue becomes a kind of contest in which patient and nursing personnel are matching wits. That the odds in many cases are against those charged with the safety of the patient is understandable. Besides the ever-present element of human fallibility there is the vast discrepancy in the absorption of mind—the pre-occupation—on the two sides. The contest is between a mind with just one thought and purpose morbidly intensified and that of the nurse, which like any mind may find it difficult to focus so intently and continuously through every moment of her tour of duty and without distraction on the single objective of uninterrupted supervision. If there is a momentary lapse of attention, it is less likely to be on the part of the patient. In one case the patient asked the nurse to bring a glass of water from the adjoining bathroom. 'Please let it run cold,' he said. While the water was running cold, whatever time that may have been, he strangled himself with a suspender strap fixed to the bedpost by simply rolling out of bed. You ask how it could happen. Well, it happened."

The type of personality who is considered such a suicidal risk is he who is inclined to self-depreciation and self-blame, who fears that because of his pronounced insomnia, he is going to "lose his mind," who worries excessively over his physical health, who fears that he might lose control of himself and possibly harm other people, who is seclusive, restless, agitated, tense, anxious, worried and who suggests the picture of hopeless despair.

Jameison in tabulating the results of ten patients hospitalized because of depressive psychosis noted that one of these patients suicided three days after leaving the hospital and the remaining nine had taken their lives within only five months' time. Thus would he exhort relatives against removing suicidal patients from hospitals against the advice of the therapists. He would also impress upon the minds of relatives that occasionally a patient appears suddenly to improve just before he suicides. This symptom is often misleading and the relative secures the patient's discharge though the therapist knows only too well that oftentimes the patient assumes a totally different—yes, even notably improved appearance—only because he thinks that he has finally and carefully consummated effective plans for carrying out his suicide.

Dr. Jameison has likewise warned against the danger of mood swings in manic-depressive reactions. Some of these patients experience manic phases and depressive phases; but in the short duration between

these phases, the patients appear to be well. Unless relatives understand the longitudinal picture of this mental disease, they are likely to insist upon the discharge of such a patient at the most inopportune time, for if the patient has undergone previous attempts at suicide, any opportune circumstance for repeating the attempt is likely to prove tragic. Oftentimes depressed patients with circular reactions, after their depressions have lifted, tend to complain about their hospital environment and in projecting their inner distress thereon, contend that the hospital restrictions are prolonging their illness. Because at this stage the patient appears improved, as far as his depressive features are concerned, his relatives agree to remove him; but actually he is potentially more suicidal than he has been at any other time. Such mistaken moves frequently result in tragic consequences, as such patients usually survive only a matter of days, weeks or a few months at most. It is often difficult to convince relatives of the risk incurred in such matters seen repeatedly by the therapist; hence the dire need for convincing the public that all mental diseases are not alike.

Another type of suicide might be termed the *compulsive* kind. Into this category fall those unfortunate individuals who feel as if they are driven to a commission of the act. Frequently the patient feels that accusing voices are urging him to kill himself. Many schizophrenics and some individuals showing schizoid traits, as well as seniles, arteriosclerotics, some paranoids and paretics are potential suicides of compulsion.

There is also an *impulsive* variety of suicide. Those who suddenly seek revenge or feel grossly disadvantaged or ill-treated, as well as impetuous, emotionally unstable lovers engaged in quarrels, fall into this category.

The *auto-suggestion* group has been previously referred to as those who, because of a predisposition to suicide, follow the example of another member of the family who had suicided. It is noted that during a fifty year period, twenty-three suicides took place during four generations of the Briggs family in Connecticut.

The *anhedonic* suicide is one who, finding no value or interest in life, resorts to self-destruction because of sheer boredom.

Occasionally *physiologic* suicides are also encountered. These are the individuals who, because of the severity of physical ill health, discouragement and disappointment, no longer experience any joy in life. They long for death and even resolve to die. It appears that there actually are many such patients who, because of a somatic diathesis, are able to carry out such a resolution. Many sufferers of cardiovascular disease, lung disorders, diabetes and abnormal nerve conditions fall into this category.

Perhaps the last well-known type might be termed the *juvenile* suicides. Fortunately, suicide in children is comparatively rare though there are found some who, when they experience unhappiness, defeat and misery, seek relief from their discomforts through self-destruction. Included in this class are some psychopathic individuals, some individuals of sensitive temperament, some who have a predisposition to suicide and some who are psychologically unstable. It is believed that children follow their inclination to suicide at the height of emotional release and therefore impulsively (and oftentimes, suddenly) attempt suicide. Some children have been known to attempt suicide because of a desire to be with a deceased loved one. One little boy recently killed himself because, as an antemortem note signified, "I got a 'D' on history and I could not stand another whipping." Another child hanged himself in the barn because he had seen a lad do the same in the motion pictures. Another girl swallowed lysol because she was uncommonly tall for her age.

Closely related to genuine suicide are attempts which sometimes prove to be spurious. These we might call *suicidal gestures*. Some such gestures, not originally intended to be serious, are sometimes accidentally successful and hence very tragic. Usually they are designed for the purpose of attracting attention or sympathy, or for securing revenge.

Dr. Karl Menninger has stated that, psychoanalytically considered, every genuine suicide should involve three elements, dying, killing, and being killed. He postulates that the absence of any of these three factors disproves the suicide, thus labeling the attempt a *gesture* instead. Capt. George N. Raines (M. C.) U. S. N., calls attention to the fact that the age is a rather reliable determining factor in such an uncertainty, and adds that if the suicidal gesture occurs in mid-life or late life, it has all the warning qualities of an actual suicidal attempt; but if it occurs between the ages of 20 and 35, it may have no bearing whatsoever as an indicator of actual self-destruction.

Basic Factors in Suicide

The following miscellaneous findings will, perhaps, serve as pertinent pointers in a basic consideration of suicide:

Regarding the *methods* employed in self-destruction, it is noted that the personality of the individual has some connection with the method employed for the appropriate end-reaction of a psychic conflict. Also significant are suggestion and availability of means. The methods might be thought of as active (or aggressive) and passive (or reception). As a usual thing, though not consistently so, women employ the passive methods, such as poisons, gas and drowning. Men employ the active ones, including cutting, shooting, burning (and electrocution), jumping from high

altitudes, hanging and voluntary starvation. Usually the individual continues to employ the same method which he originally used. In hospitals where restrictions are numerous, the successful method is generally asphyxiation through hanging. Scarfs, cords, belts, handkerchiefs, ties and various articles of linen are used. Sometimes hemorrhaging from self-inflicted wounds also brings on death.

Regarding *professions and occupations*, it is believed that suicides occur more frequently among doctors, lawyers, soldiers, other professional men, commissioned officers and college students. Less frequently they occur among monks, priests and those having occupations out-of-doors.

The Negro, as a *race*, is not given to suicide. Attempts at suicide are made among Negroes, but they are only rarely successful. It is postulated that perhaps because of a comparative absence of melancholia (the most telling factor in suicide) among the Negro, this condition prevails. It is also observed that self-mutilation and castration practices—bearing a close correlation with suicide—are also infrequent among Negroes. In mulattoes (or mixed Negro and Caucasian blood), it is observed that the greater the mixture, the greater is the tendency to depression.

The *age* peak at which suicides take place is 45 years among males with that for females slightly lower. Though large numbers of females attempt suicide, they are not nearly so successful in their acts as are males. The ratio for the two sexes stands at three suicides for males to one for females.

The *time* of day at which most suicides are perpetrated is usually during the early morning hours generally between 5:00 and 7:00, though others occur during the afternoon and evening hours as well. Suicides are somewhat rare in the middle of the week, generally occurring in the community on Sundays and Mondays. Usually the highest incidence occurs in the month of November. The trend descends to a low in January, rising suddenly in February. Another rise occurs in June, being maintained through July and August.

It is noted that the forces of religion act as a deterrent to suicide. Long has there existed the opinion that a higher incidence of suicide prevails among Protestant than among Catholics though this is still a matter for further investigation and clarification.

Preventive Measures

The writer herewith presents in outline form some preventive measures to be used with potential suicides within both the community and the hospital.

1. Moral example and persuasion are efficacious in certain cases but are of no value when the intelligence of the patient is no longer intact. Some incurable patients who are perfectly lucid may be benefited by these measures; but in cases of depression and in

delirium the physician will lose time if he resorts exclusively to psychological arguments.

2. Measures of mental hygiene are more important.

a. The patient's hours from morning until night should be divided between *physical exercises, meals, distractions* and *moderate work*, and he should be obliged to follow this discipline to the letter.

b. He should not be left to himself.

c. The interest taken in an interesting occupation has often cured patients of their old ideas of suicide.

3. Special sanitarium is advised in cases where the form of treatment outlined above fails.

4. No sedatives should be prescribed to patients left at liberty as they may use these drugs to poison themselves.

5. Isolation should be used as an emergency method.

a. in cases of psychopaths who have attempted suicide.

b. in epidemics of suicide.

c. in hysterical patients who threaten to kill themselves.

d. in the case of hypochondriacs.

6. It is very exceptional that treatments at home can replace isolation in a hospital. If kept at home, he must be placed in a room and watched continuously day and night.

7. Before giving drugs it must be remembered that physical and moral hygiene play a great part in the treatment of these patients.

a. rest in bed.

b. quiet; semi-darkness.

c. baths, massage and Swedish gymnastics.

8. If ideas of suicide are due to some intoxication such as alcoholism or general paralysis, the proper treatment should be instituted at once.

9. If the cause remains obscure but there are signs of endocrine disorders, opotherapy becomes necessary.

10. There is often a disequilibrium of the sympathetic system in these patients, and this should be treated.

11. Opium gives good results in all cases. Laudanum in progressive doses or morphine in acute crises has an excellent sedative action. The toxicity of morphine can be reduced by adding scopolamine. During the last few years many new alkaloids have been prepared which are not very toxic and which are not habit forming.

Therapeutic Measures in Special Sanitarium

1. Patient is undressed and searched on admission.

a. All weapons, knives, scissors, needles or pins should be taken away from him and the same is true of all drugs.

b. Clothing should be reduced to a minimum, and any article of clothing which can be transformed into bonds such as suspenders, lacings, belts, soft collars, neckties, stockings or handkerchiefs should be removed.

2. An inspection should be made after each visit of his relatives.

3. Patient should be placed in bed under constant watch of a nurse. He should be allowed to rise only to go to the toilet.

Under these conditions there is no danger of suicide by means of firearms or knives, but the same is not true with regard to hanging. A patient may hang himself in bed unless carefully watched, under the bed clothes. In some cases the nurse has carefully watched her patient during the entire night and has found him hanged in bed in the morning.

4. The patient sometimes endeavors to commit suicide by refusing food, by ingesting foreign bodies or by means of drugs. Ingestion of foreign bodies can scarcely occur if the patient and his surroundings have been properly searched.

5. Meals should be served to the patient in bed and should not include any dangerous food such as fish containing bones. Meat should be cut in advance so that the patient will need only a spoon.

6. Hunger strikes can be treated by nasal feeding.

7. Poisoning from drugs can be avoided if toxic substances are ordered very infrequently, and if the patient is watched while the drug is being given. Care should be taken that he swallows the drug, and does not save it until a poisonous dose is obtained.

a. For this reason it is best to treat the patient by hypodermic injection.

b. Tablets or pills which can be concealed in the corner of the mouth should never be given.

8. Medical treatment, of course, varies with etiological factors.

Three Correlates of Suicide

Before closing this paper, the writer would like to mention briefly a few correlates of suicide—self-mutilation, castration and homicide.

Very often individuals who are prompted by the same motives present in potential suicides turn to *self-mutilation*. In an effort to atone for past misdemeanors, shortcomings, guilt and sins, some in-

dividuals inflict infirmities upon themselves by inhaling or imbibing caustic substances, fracturing heels, severing hands, plucking out eyes, destroying teeth, pulling out the hair, or artificially inducing abscesses, tumors, throat and lung ailments, as well as skin infections. Sometimes these mutilations are carried out for the purpose of gaining sympathy or attention; sometimes for expiation; and sometimes through a willingness to sacrifice a member of the body rather than face the uncertainties of future through suicide.

In time of conflicts as the Second World War, for example, self-mutilation is often closely correlated with mayhem (the hurt to an individual's body, by which hurt that individual is rendered less able in fighting, either to defend himself or to annoy the foe). Self-mutilation, at such periods is not easily distinguishable from malingering. Many individuals evidencing shyness, fear, insecurity, anxiety, irritability and similar emotional reactions to combat, also many psychopathic personalities, resort to so-called malingering though in frequent instances true identification of the act is practically impossible. Psychiatrist Robert L. Garrard recalls that during the last World War, of three hundred hospitalized cases of self-inflicted wounds, only sixteen failed to pass the investigation of the Inspector General's Department and as a result were court-martialed. He reminds also of the difficulty in distinguishing among injuries due to carelessness with no conscious desire for self-injury, accidental injury, and purely pre-meditated cases of self-mutilation.

Not infrequently also are cases of *castration* encountered among personalities in whom auto-sadism is a predominant factor. In an attempt to castrate themselves, potential suicides and others frantically attempt to tear away the genitals, to bind tightly or even to sever entirely the penis. Dr. Garrard relates the following case in the *Edgewood Medical Monographs* (1950).

"He expressed hostility and resentment toward the Army, his draft board and all authority, saying he hates uniforms and trusts no one. He said his trouble began when the chairman of his draft board refused to release him so he could join the Air Force and earn enough to support his wife who was then three months pregnant. While in the Army he says he was very despondent, being away from his wife, and he began to mutilate his nipples and penis. He took a razor blade and split the penis above and below the meatus about $\frac{1}{4}$ inch, so that the glands were partially bifurcated. He said he could not get a pass or furlough to be with his wife for her delivery. Commenting on the mutilation he said: 'It all started because I could not be with my wife for her delivery.' As a matter of fact he went AWOL and was at home when she delivered. On returning to his post he felt it was most unjust when he was shipped to Cape Cod, Massachusetts. In less than two years he was separated on a medical discharge with a diagnosis of anxiety

neurosis. He was so hostile toward the draft board chairman that he did not return to his native state, fearing that he would run into him and kill him. Even yet he says he turns to drink when he thinks how he was treated by the draft board. During 1945 his left nipple and breast became swollen and a nodule developed, requiring amputation. This evidently was brought on by long-continued self-mutilation of the nipple and breast. Before leaving the Army, patient had decided he was not fit to be a parent. In 1946, while in New Orleans, he persuaded a surgeon to sterilize him. He has continued to mutilate his right breast by pushing hairpins into it and forcing his wife to chew on it during intercourse, so that it is now enlarged, indurated and has been infected several times. Amputation has been planned and postponed, due to the infection. The wife of this patient reports that they are sexually compatible, though patient talks of wanting to be a woman and always wants her to take the initiative and to bite and punish him in order to make his orgasm more complete. He prefers fellatio to conventional sex relations. She reported that he pushes needles and hairpins into his nipples, to 'get a sensation' and he wants to pierce her nipples. He also wants to pierce the lips of her vagina and put rings in them. This veteran is addicted to alcohol and at times becomes abusive and destructive in the home. He has spent considerable time in a veterans hospital during the past few months."

Very closely related to the suicidal act is the *homicidal* act. It has been noted that in England fully $33\frac{1}{3}$ percent of the murderers terminate their lives in suicide. Daily accounts are recorded of a homicide who was responsible for one, two or sometimes many more deaths before he terminated his own life or at least attempted to do so. Such, within recent times, was the case of Howard Unruh who murdered thirteen victims at one fell swoop and then turned the gun upon himself in an attempt which was intercepted.

The Problems of Suicide—a Challenge to Research

Thus far this paper has sought to show that suicidal tendencies are present in practically all of us, but our reactions to the trends differ markedly. In fact, most of us escape suicide; nevertheless the incidence continues so great that self-destruction is still one of the leading causes of death. In the field of psychiatry, it is actually the leading cause except in the oldest age groups. Psychiatrists state that each day they witness aborted or frustrated attempts. Occasionally, however, as has been stated, an attempt in a well-ordered institution inexplicably ends in tragedy. Psychiatrist Russell A. Anthony, writing in the *Cyclopedia of Medicine, Surgery and Specialties* (1951), says: "Unfortunately there are no rules of thumb in preventing suicide . . . Even in the best types of psychiatric hospitals with constant supervisions patients have been able to commit suicide."

Today much research is needed into cases of suicide

and its correlates. What should be done for the sensitive little girl who, because of the disfiguring birthmark on her face, prefers to "end it all," or for the over-grown six and a half foot sixteen-year old lad who is unable longer to stand the taunts and jibes of his school mates? What can prevent the useless deaths of frustrated Japanese maidens who fling their small bodies into the raging inferno of a Fujiyama? What measures can prevent the slow, agonizing death of a bichloride of mercury victim? What is the best method for treating the individual who swallows spoons, screws and safety pins, or frantically batters his head against walls and attempts to drive nails into his scalp? How can one deal with speeding motorists (who, in reality, are *concealed or unconscious* suicides), who operate vehicles at an incredibly fast speed toward deliberate accidents? What should be done to safeguard the welfare of the sufferer who commits suicide during a brief period of delirium only characteristic of his curable malady?

Dr. Nolan D. C. Lewis contends that of all pathologic processes in the field of psychobiology, suicide is the most profound, hence the very pressing need for a more intensive research. Though, as has been noted here, every suicide has a motive, for some acts of self-destruction, it is impossible to ascertain the motive. It is agreed, however, that the increase in suicides can not be attributed solely to psychic and physical distress. It must also be recalled that many cases of suicide occur outside the hospital walls, and often these cases are never studied. Though many such cases had been formerly seen by a physician, he had not perhaps grasped the significance of the situation

which later terminated in tragedy. Hence arises the necessity of recognizing dangerous warning signals such as suicidal preoccupations, development of morbid thoughts and reactions, pronounced hypochondriasis, sudden improvement in certain types of mental illness, great concern over insomnia, depression with ideas of self-accusation, guilt and self-depreciation, fear of losing control of oneself, as well as previous attempts at suicide.

It is vital that not only the physician (not psychiatrically-oriented) but also the family of the mentally ill patient be sensitized to the problems of suicide. How necessary is it for the physician to analyze personality in order to forestall self-destruction in his patient. How vital is it that he understand how seemingly insignificant details are highly meaningful to the mentally ill patient.

Suicide must be traced to the early formative fears of childhood when the structure of the ego and super-ego is being formed. Education and enlightenment on sexual matters, as well as a more tolerant and understanding attitude on the part of physicians and parents regarding adolescent drives and relationships, will serve to decrease the incidence of suicides.

The need to establish more clinics for providing psychotherapy for the distressed, to disseminate more information regarding suicide among the general public, to include more information on the subject in medical books for students and physicians, and to provide for a more profound research must challenge the general public to a solution of the stupendous problems of suicide.

The Physician and the Atomic Bomb

V. P. BOND, Lieut., MC, USN,
M. C. FISHLER, M. D., Ph. D.,
W. H. SULLIVAN, Ph. D.
San Francisco

(Every physician, whether in a so-called strategic area or not, should be acquainted with the basic principles of the atomic bomb as it might be related to medical practice. We are, therefore, publishing this article, which originally appeared in *California Medicine*, December, 1951, since it is one of the clearest and most informative discussions of the subject which we have seen.—Editor)

Atomic detonations are essentially of two types: contaminating and non-contaminating. The only non-contaminating burst is the high air burst, since it does not result in the contamination of the ground with radio-active bomb residue. This type of burst results in blast, thermal and ionizing radiation injury (often combined in the same patient).

The only injurious agent peculiar to atomic warfare is ionizing radiation. With a high air burst these effects are due mainly to gamma rays, and they are no longer present after the first few seconds following the explosion. Although only about 15 per cent of the deaths resulting from this type of burst are likely to be due primarily to ionizing radiations, exposure to the latter may well complicate recovery from trauma.

Since there is a latent period of a number of days between the initial and later symptoms and signs of whole body radiation exposure, it does not constitute an emergency and can be treated after the initial period of the disaster has passed.

With the detonation of a contaminating burst (a surface, underwater or underground burst) the radii of damage from blast and thermal radiation are considerably less than with a high air burst. Two types of radiation may result from the radioactive fog (base surge) formed after an under water burst—transit radiation and deposit or continuing radiation. The deposit radiation includes that resulting from inhaled or ingested radioactive material as well as that deposited on clothes or skin. Bomb residue contains material which would localize in bones if it entered the body, and much of it has a long radioactive and biological half-life. It would thus bombard the radio-sensitive bone marrow for long periods.

Fortunately, the materials which would localize in bone are poorly absorbed from the gastrointestinal tract and lungs.

In general radiation injury to a person exposed to a contaminating burst should be reckoned primarily in terms of the penetrating gamma radiation to which he was exposed, rather than in terms of possible internal radiation from ingested or inhaled contaminants.

The principles of broad planning, careful triage, decentralization of medical aid, intelligent stockpiling, and the greatest good to the greatest number are to be stressed in medical defense planning.

The best appraisal of exposure and its degree of seriousness is, as it is with disease in general, an accurate clinical evaluation by the physician. The tempo of the disease is an important aid in evaluating severity of exposure. The use of the dosimeter in judging the fate of a given individual is, at least at present, of limited value.

The purpose of this article is to present in a concise form aspects of atomic warfare that are of importance to the practicing physician who may find himself faced with the problem of caring for the victims of an atomic disaster. In the event of atomic attack on our cities the physician will be a key figure in providing health services to the victims, and it is therefore of the utmost importance that he be fully cognizant of the situation he may have to face shortly after the attack.

The number of dead and injured in the event of atomic attack would be overwhelming. For example, if this were to occur in a city with a population of a quarter of a million, 50,000 to 100,000 injured and 5,000 to 20,000 dead are not unreasonably high estimates. Thus, because of sheer numbers the casualties could not possibly receive what would

normally be considered adequate care. In consequence of this, detailed advance planning is of the greatest importance. Such plans are dependent on a careful evaluation of the probable types of injuries, the relative numbers of each type, and the urgency of the need for treatment.

Any predictions of numbers of dead and injured can only be rough estimates at best, for the actual numbers would depend on the number of bombs used, the kind of bursts, the sizes of the bombs, the shape and topography of the targets, the weather, the time of day, the population density, etc. Most predictions have been for the air burst only, for this use of the weapon is believed to be the most destructive. However, the major effects of bursts of any type should be considered. A miss could conceivably convert what was intended to be an air burst into an underwater or surface burst.

KINDS OF ATOMIC DETONATIONS

Atomic detonations may be segregated into contaminating and non-contaminating. The only burst of non-contaminating type is the high air-burst, in which blast, heat, and ionizing radiation expand their energy over a wide area in the course of a few seconds. As the cloud ascends, all radioactive bomb residual is carried aloft and no significant^a contamination of the ground with radioactive material occurs.⁸ Essentially no ionizing radiation other than immediate burst of gamma rays is encountered. It is as though a giant x-ray machine were suddenly turned on in the sky, and were left on for approximately one minute and then turned off. And just as one would not hesitate to enter an x-ray room and handle the patient immediately after the beam is turned off, so it is safe for rescue teams to enter the bombed area *immediately*.

A "contaminating" burst can be defined as any detonation in which the fireball comes in contact with the earth's surface. This results when the detonation occurs either on or below the surface of the earth, or at an altitude such that the "fireball" can touch the surface. The low air, the surface, the underground and the underwater burst are of the contaminating type. In general, the radii of damage for blast and thermal effects are decreased as compared with those of the air burst. The ground (or water) is actually contaminated with residual bomb products, both fissioned and unfissioned. Also, activity induced in the earth or water by neutrons liberated in the fission process may rise the general level of contamination.

With a burst of this type, then, the bombed area actually becomes radioactive, as though radium or other radioactive material had been spread over the area, and this radioactive material continues to emit ionizing radiation for long periods after the detonation. With a burst such as the underwater detonation, for

^aThere could be some ground contamination resulting chiefly from a "fallout"; but the levels of activity would be very low and would constitute a minor hazard compared to the gravity of the over-all situation.

example, it is likely that significant quantities of radioactive material can be carried well beyond the range of major blast or thermal damage.

The chief distinction between the contaminating and non-contaminating bursts lies in the presence or absence of residual radioactivity in the bombed area after the detonation. Blast, heat, and nuclear radiation may be present in varying degree in bursts of any type, but the magnitude of each effect in producing casualties will vary in accordance with the manner in which the weapon is used.

THE AIR BURST

The bursts of various types and the important phenomena associated with each have been reviewed. The effects of the high air burst will now be considered further. And while blast, heat, and ionizing radiation are treated separately, it is well to keep in mind that these phenomena rarely produce effects singly and, therefore, injuries generally would be multiple in nature.

Blast Effects

The effects of blast on man can be divided into two categories:

1. *Direct* effects resulting from interaction between the shock wave and the human body.
2. *Indirect* effects resulting either from objects set in motion by the blast striking the body, or from the body striking stationary objects.

Direct effects will be mentioned only to eliminate them from further consideration. There are essentially no circumstances during or following an atomic burst in which direct blast pressure could injure a person who would not be killed "many times over" by other effects.

Indirect blast injuries are mechanical injuries and are similar to those produced by falls, by blows with blunt instruments, or by automobile accidents. They consist of contusions, lacerations, simple and compound fractures, internal injuries, penetrating wounds, crushing injuries, etc. Injuries from flying glass would be extremely common. In the Japanese disasters mechanical injuries among survivors were in general of a minor nature; the absence of major trauma among survivors is ascribed to the fact that victims so afflicted could not escape the conflagration which developed in the first few hours after the burst.¹² In cities of more fireproof construction, or under improved conditions of rescue, the number of survivors with major traumatic injuries might well be much larger than it was in Japan.

The kind of mechanical injury referred to is, of course, not peculiar to the bomb. But it must be remembered that there might be *thousands* of victims with injury of this type for whom treatment would

be needed almost simultaneously. There would be neither time nor facilities to care for all of them adequately.

Thermal Effects

The thermal radiation from the exploding bomb can cause injury in two ways:

1. The radiant heat may act directly on exposed personnel and produce *primary burns* or *flash burns*. This kind of injury would happen only to people who were in the open or near a window.
2. The radiant heat can char structures, clothing and other combustibles in the affected areas, and those burning objects may themselves inflict burns. Such burns are termed "*secondary*" burns.

Actually, radiant heat probably would contribute much less to the igniting of materials than would overturned stoves, electrical "shorts," etc. At any rate, in the first few hours following the burst, a widespread conflagration would kill potential survivors trapped in the wreckage or otherwise unable to leave the scene.

The extreme rapidity with which the thermal radiation is delivered and the relatively poor heat conductivity of the skin results in burns that are in general superficial and painful, but which may be deep in victims near ground zero.⁹ "Shadow effects" are common; a man be shielded by buildings, clothes, or even by body contours.¹² Radiant energy burns generally are on one side of the body only. Patterned clothing may permit burns beneath dark-colored areas while the skin beneath the light areas is not burned.

Burns present no new problem, but it must be recognized that they are large open wounds and that shock and infection are a serious threat. Flash burns are not uncommon in industry, and certainly the treatment of burns from flaming structures is in every physician's experience. The well-known factors of the location, the degree and the body area involved enter into the appraisal of the severity of the burn.

Effects of Ionizing Radiation

The only injury peculiar to atomic warfare is that caused by ionizing radiation. However, in the event of an airburst ionizing radiation would not be the chief cause of mortality. Only 15 per cent of the Japanese fatalities are attributed primarily to ionizing radiation.¹² But if measures are taken to prevent thermal and blast injury, ionizing radiation would assume much greater importance because it is more difficult to shield against.

Radiation injuries resulting from a high air burst are chiefly the result of the gamma rays which are liberated during the first few seconds.^{9, 10} as we stated,

⁹The point on the ground nearest the center of detonation.

¹⁰The effective range of neutrons liberated during the fission process does not extend beyond the range of total destruction. However, they may assume greater importance in that, if shielding were available to protect adequately against heat, blast, and even gamma rays, neutrons might still be lethal.

these penetrating gamma rays are similar in all respects to high-energy x-rays. The biological effects of such rays can be duplicated in the laboratory by the use of either high energy x-ray machines or by use of gamma ray sources.

The sudden burst of gamma rays from an air burst may be important from two aspects:

1. Large doses of the rays will produce the clinical picture of acute radiation injury,⁷ or the picture as it may be modified by partial shielding of the body.
2. With smaller doses, although the complete clinical picture of acute radiation injury may not be evident, exposed persons may become debilitated and particularly susceptible to infection.¹³ This complicating factor may interfere with healing of burns and traumatic injuries.

The clinical picture of acute radiation injury can be characterized as follows:¹⁰

Following an exposure to a large dose (300 r to 500 r) anorexia nausea, vomiting, malaise, fever and thirst may appear in the first few hours. These symptoms subside and are followed by a period of variable length (a few days to a few weeks) in which the patient is apparently well. During this period leukopenia, thrombopenia, and disappearance of reticulocytes become evident. A decrease in lymphocytes appears early and the granulocyte changes follow. Anemia is slow in developing.

The latent period usually ends with the onset of epilation, usually of the head, and often of the armpits and pubes. This is reversible. Anorexia and malaise return, as does a stepwise-rising fever. Pharyngitis and oropharyngeal ulcerations (agranulocytic angina) appear; then bleeding tendencies—petechiae, bloody diarrhea, nose bleeds, purpuric spots, etc. This may be followed by the development of enteritis, hemorrhagic lobular pneumonia and other infections that may result in death. Occasionally, a more prolonged course characterized by debilitation and emaciation may precede death.

In patients who recover, the signs and symptoms of the disease disappear approximately in the following order: Pharyngitis, diarrhea, petechiae, fever, and oropharyngeal lesions. Recovery is associated with an increased leukocyte count in the peripheral blood. However, a patient in whom the leukocyte count is returning to normal may die. Anemia in survivors extends into the period of convalescence.

The pathogenesis of this disease insofar as it is understood at present, is as follows: There are three tissues affected in the main, the bone marrow, the lymphoid tissue, and the gastrointestinal tract. The disease in its terminal stage is not unlike advanced aplastic anemia. With large doses of radiation the result is aplasia of the bone marrow. This results in

the blood picture which was described. The low leukocyte count coupled with disturbances of other immunizing mechanisms contributes to a lowered resistance to infection, which in turn permits development of oral, gastrointestinal and pulmonary lesions. There is an absence of cellular tissue reaction around these infectious lesions.

The decreased platelet count is probably an important cause of the hemorrhagic tendency. Also involved possibly are an increase in circulating heparin-like substances in the blood, and an increased capillary fragility. The lack of erythrocyte production and the bleeding tendencies are mainly responsible for the anemia. Infection may also be a contributing factor to the anemia. Depression of the erythroid elements of the bone marrow is pronounced. This is reflected in the reduced uptake of administered radioactive iron into the erythrocytes following total body radiation.

The diarrhea, which is often sanguineous, has been explained on the basis of edema of the bowel, denuding of the mucosa secondary to infection, and hemorrhage.

A most important characteristic of acute-radiation injury is the latent period: A severely exposed person may have no serious signs of illness for a number of days. It should be recognized, then, that acute radiation injury does not constitute an emergency and can be treated after the trying initial period of disaster is over.

The dose of gamma radiation necessary to produce death or serious illness depends on several biological and physical factors. The dose necessary to kill approximately 50 per cent of a group of exposed human beings⁹ is usually taken to be 44 r, although a few may die after doses as low as 200 r and a few may survive doses as high as 600.⁴ Hence it is seen that a large individual variation in susceptibility exists. In addition, the previous condition of the exposed person is important in determining the response and prognosis. A sick person is more likely to have serious effects from a given dose of radiation than is a well one. Subclinical or low-grade infections that in themselves would not be lethal may, in conjunction with a usually sublethal exposure to radiation, cause death.³

The existence of partial body shielding may be important in establishing the prognosis of a patient, and victims should be questioned about possible partial as well as total shielding. To take an extreme example, if 10,000 r were directed to a small region of the body, i.e., the hand, the victim would not die

*A species difference exists,⁹ the LD₅₀ for rabbits is about 750 r; for rats, about 650 r; for goats, about 350 r; for dogs, about 300 r. Since most animals that die after acute total-body irradiation do so in 30 days or less, the period of observation for lethality is taken as 30 days, e. g., the LD₅₀ 30 days is determined. Many severely exposed human beings, however, die between the 30th and 60th days after exposure.

of "acute radiation injury." But if 400 r were delivered to the whole body about 50 per cent of victims would die. If the abdomen were completely protected with lead,¹⁰ the dose necessary to kill 50 per cent of exposed persons would be of the order of 1,200 r. If everything but the abdomen were protected and the abdomen irradiated, the LD₅₀ dose would be about 600 r. The abdomen-shielded persons would probably have a syndrome different from that of those who received whole body irradiation, and the time of death the abdomen-irradiated persons would probably be earlier than that of the abdomen-shielded. Head irradiation alone probably would produce death at doses of the order of 1,200 r. Obviously, these figures were derived by extrapolation from animal experiments² and can be regarded only as rough approximations.

It was stated earlier that the energy of the gamma rays is very great.⁸ This high energy is of importance in that it can produce essentially "whole body" radiation in man. This may be clarified if it is pointed out that if small animals such as the rat or mouse are irradiated with 250 KVP x-rays, the energy absorbed at different depths of the animal will be sensibly the same. However, if a large animal the size of a man is irradiated with x-rays of the same energy, the irradiation of the tissues farthest from the beam would be creased by a factor of approximately ten. If higher energy or more penetrating radiations are used, the dose received throughout an animal tends to be more uniform.

The total dose of radiation that may be received from a high air burst is delivered over a few seconds. There is no time for recovery during irradiation and the effects are maximal. If the total dose is given over several days, for example, as opposed to a few seconds or minutes, the dose necessary to produce serious damage is larger. If intermittent or repeated exposure is experienced, the dose necessary to produce serious damage is also increased. This, again, is because recovery is permitted during irradiation.

Numbers of Injured

The effects of blast, thermal radiation, and nuclear radiation have been considered separately. It is of importance to consider these injuries collectively, to gauge the relative number of each kind and to consider where they occur with respect to ground zero.

It is stated frequently that (assuming detonation of the nominal or 20 kiloton bomb) of the people present in the zone extending from ground zero to one-half mile from ground zero, 90 per cent or more would be dead or injured, and that in the second zone extending from one-half mile to one mile, some 80 per cent would be dead or injured. Such a representation, however, is in a sense misleading, for the more remote the zone from ground zero, the greater the population in

it because it is of greater area. When 90 per cent or more of the population of the innermost zone are dead or injured, this is a large percentage of a relatively small number of people. Also, the physician would be primarily concerned with the injured survivors, and from this standpoint it is necessary to consider that most of the people in the innermost zones would be killed. Of more importance to the rescuer is a consideration of the probable number of *survivors* in each zone and how many of them are likely to be injured.

Exact figures are not available but it is probable that most of the injured would be found in the zone extending from one mile to a mile and a half from the center of the blast. Considering again that radiation is falling off rapidly at one mile while heat and indirect blast effects are still important at two miles, it is obvious that in the zone where most injuries are likely to occur radiation is not a significant factor. In other words, most of the injured there would have blast injuries or burn injuries or both.

However, it should be stated also that a sizable percentage of survivors needing treatment would be in the zone extending from one-half to one mile from ground zero, where gamma rays are still effective. Hence radiation damage can be expected, not only as a primary entity but as a serious complicating factor. The importance of radiation should not be over-emphasized—or discounted.

It should be pointed out again that with modern structures providing protection against heat and blast, and with improved rescue techniques, the chance of survival closer to the bomb is greater and hence the probability of radiation injuries is increased. It should also be reemphasized that only the burned and traumatized victims will need emergency treatment, for lesions and accompanying shock; acute radiation injury, or complicating radiation dosage, does not constitute an emergency.

As to the numbers of casualties, totals are dependent on the size of bomb, type of bomb, number of bombs used, density of population, etc. But a figure of 50,000 persons who need treatment in a city of 250,000 or more is conservative; 75,000 or 100,000 is not unreasonable. Furthermore it must be remembered that treatment of all *simultaneously* would be required. Relative numbers of casualties can be gained from the following hypothetical breakdown of injuries:¹² Wounds, 70 per cent; burns, 65 to 85 per cent; radiation injury, more than 30 per cent.

Perhaps of more practical value would be information on the expected diagnosis and outcome per 100 casualties. This could be represented as follows:¹¹ Wounds (no burns), 60; burns (with or without wounds), 40; radiation injury, any degree, 30; died (all causes), 25; died of burns, with or without other injuries, 19; died of wounds, 6.

¹⁰*The weight of material required makes it appear at present that a partial body "armor" against bomb radiations is impractical.

THE CONTAMINATING BLAST

The radius of damage from blast or heat with a burst of the contaminating type would be, in general, less than that of the high air burst. With the sub-surface burst, effects of radiant heat might be entirely absent. With an underwater burst off shore, blast may be no problem at all to shore establishments. With the underground burst, it is not unlikely that an earthquake-like phenomenon might cause destruction at a considerable distance.

As with the high air burst, direct blast effects (in air) would be of no practical concern. Indirect blast injuries and burns, if they are present, would not differ qualitatively from those of the high air burst. There might be few or no flash burns and relatively larger numbers of flame burns.

As to radiation encountered with the contaminating burst, some elaboration is necessary. For example, in the underwater burst, as the large mass of water thrown into the air by the detonation falls to the surface, a highly radioactive fog or base-surge forms, which rolls over the bombed area and then ascends into the sky.

Radiation delivered from the base-surge can be divided into two types, transit radiation and deposit or continuing radiation. The transit radiation is delivered as the base-surge rolls over the area and ascends into the sky. Again it is as though a giant x-ray machine had been slowly drawn over the area and then pulled up into the sky out of range. Radiation of this type is delivered to the bombed area over a matter of minutes. It then disappears.

The transit radiation of medical importance, then, is delivered over a short period of time, as with the air burst, and is composed of gamma or penetrating rays like x-rays. Like the high air burst, it can produce total body radiation resulting in acute radiation injury. But as the base-surge rolls over the area, it rains or deposits radioactive materials on objects and personnel below. It is as though a large quantity of radium or other radioactive material had been spread over the bombed area.

The deposit radiation can get on the clothes and on the skin. Here again the x-ray analogy may be used. But here the "x-ray machine" has not been lifted out of range; it remains on the clothes or on the skin. Still, penetrating gamma rays are given off; still, whole body radiation resulting in acute radiation injury may be produced.

And suppose a person even ingests or inhales the base-surge? Here he has taken numerous "small x-ray machines" or radioactive isotopes into the body; they continue to give off penetrating radiation, the entire body can be irradiated, and acute radiation injury may occur. Again, if large amounts of radioactive fog or mist from the bomb are deposited on the clothes

or skin, or even enter the body, acute radiation injury may result.

The penetrating gamma rays are the chief or "controlling" hazard to personnel contaminated shortly after the detonation. But other hazards result from the deposition of radioactive material from the bomb, and in order to describe and evaluate their role it is necessary first to elaborate further on the composition of the radioactive bomb residue.

Addition to gamma emitters, the bomb residue also contains beta-emitting fission products. The emitted beta rays are termed non-penetrating, since fairly energetic beta rays penetrate only a centimeter or less in tissue. If present on or near the skin in large quantities, these rays can produce "beta burns." If beta emitters are inhaled or ingested, the lungs or the gastrointestinal tract can become irradiated.

Unfissioned bomb residue (plutonium or uranium) emits alpha rays. If small quantities of this material gain access to the bones, serious chronic effects may result. A well-known example of this type of injury is that of the watch-dial painters. These people, while pointing their brushes with their lips, ingested enough radium and mesothorium (also alpha emitters) over a long period of time to localize in the bones and cause death after several years, from anemia, infection or osteogenic sarcoma. Certain long-lived beta-emitters found in the bomb residue also localize in the bones and are capable of causing this type of damage. All such long-lived elements (either alpha or beta emitters) can be called collectively the "bone seekers" and can give rise to an "internal radiation" problem. In general, bone seekers are very poorly absorbed from the lungs and gastrointestinal tract, and relatively large quantities must be inhaled or ingested before dangerous amounts gain access to the bones.

To evaluate the hazards from these sources it is necessary to consider the relative amounts of the different types of radiation associated with a given quantity of bomb residue. Initially (soon after the detonation) the amount of gamma and short-lived beta emitters associated with any significant quantity of "bone-seeker" is very large; relatively, the gamma radiation is the overwhelming hazard. The gamma-emitters in general, however, have extremely short half-lives; as time goes on after the burst, the gamma hazard becomes very much reduced and, relatively, the "bone seeker" or "internal radiation hazard" becomes of greater importance.

The important conclusions from these considerations are as follows: Radiation injury to a person exposed to contamination at the time of an atomic detonation should be reckoned primarily in terms of the penetrating gamma radiation to which the person was exposed. Associated acute beta radiation to the skin or to the lungs or gastrointestinal tract can occur, but, in general, cases of severe exposure of this nature will not be a serious problem. If a victim is exposed to the

base-surge and ingests or inhales "bone seekers" in dangerous quantity, he is likely to have received a sufficiently large dose of gamma radiation to result in death before the "bone seekers" can become dangerous.

This does not mean that contamination should not be removed from the skin, for no irradiation should be taken lightly. But the surviving patient should be assured that even though he may have some contamination on his skin as he emerges from the bombed area, if he survives the first few weeks (acute radiation illness period) he is in all probability not doomed to the chronic disease observed in the watch dial painters.

It should be emphasized that the above considerations apply only to victims emerging from the bombed area—that is, the patients who will be seen immediately after the burst. It does not apply to clean-up or reoccupation operations at a later date when the rapidly decaying gamma emitters have essentially disappeared. Here long-lived bone-seekers can be a serious problem. In general, however, such a situation would be encountered late after the bomb detonation and operations would be organized under radiological specialists. The responsibility for radiological safety will not, in general, fall to the practicing physician.

It was stated previously that gamma radiation decreases in amount very rapidly immediately after the burst. An idea of the rapidity of the decay can be obtained from the statement that if a man is trapped in the bombed area and received 100 r over the first hour, if he remains in the area for days or even weeks he will receive a total of only about 120 r.¹⁴ Hence, if a man emerges from the bombed area and has significant amounts of radioactive contamination on him when observed medically, he should be treated as a potential radiation injury casualty. The chances are great that if he is significantly contaminated when he emerges, he has received a large dose of radiation before he emerged.

MEDICAL DEFENSE PLANNING

A resume of the physical and medical effects of atomic bomb detonations has been presented. Consideration must now be given to the means of handling the situation from the medical point of view. The bomb has exploded; the damage has been done; now what is to be done? The task is an overwhelming one. It is of such magnitude that it cannot be considered in ordinary frames of reference. Defense planning on a local level alone would be disastrous. Regional and nationwide planning are mandatory if effective countermeasures are to be developed.

The guiding principle of the defense plan must be the greatest good to the greatest number. This must be emphasized again and again. Selfish motives and self-interest must give way to unified action according to plan.

Medical defense planning is a large subject and it is obviously not possible to cover it adequately in a relatively short article. It will, therefore, be possible to cover only the principal aims of a medical defense plan and how they can be accomplished.

After an air burst has occurred in an urban area, for example, a stream of injured would begin to pour out of the bombed area, leaving behind many seriously injured who could not move out under their own power. Rescue teams would enter the stricken area to guide the stream of victims to medical aid stations and to evacuate the seriously injured. It is natural to inquire, then, into the question of when and where the injured would be cared for. It is obvious that the patient and the physician and his supplies and facilities must be brought together in time and place. Is the patient taken to the treatment center or the treatment center to the patient? In other words, just how much can be mobilized effectively and taken to the patient, and, conversely, how far can the patient be transported? In short, the patient is brought as far as his condition will permit and the availability of facilities for his care requires. Transportation to a point where safety from burning and falling debris is assured is axiomatic.

In order to decide, then, on the kind of treatment facilities needed and where they should be available, the casualties must be analyzed according to severity of injury. Persons mortally wounded would, of necessity, be transported only short distances if at all. That would include persons in shock or impending shock, those with respiratory embarrassment and those with hemorrhage. Their care would be provided for by mobile units on the spot or in casualty stations at the perimeter of the disaster area. The seriously injured who can be transported would be cared for in evacuation hospitals to the rear of the bombed area. It would be necessary to evacuate patients to neighboring cities for care. Persons with minor injuries would be attended to in the casualty stations. If at all possible the latter should be treated far to the rear of the bombed area, thus reserving the close-in facilities for the patients who could not be moved.

It follows that a very important consideration in medical disaster planning is adequate triage or sorting of patients. This would be done at the forward stations. Decentralization of medical aid with large stations. Decentralization of medical aid with large numbers of smaller mobile units and casualty stations would be desirable. Patients would not have to travel so far, and destruction of large centralized facilities would be minimized by this means.

Because of the enormous supplies of plasma, plasma substitutes, bandages, splints, essential drugs, etc., which would be needed, adequate care of victims would depend on stockpiling well in advance of expected attack. Neighboring areas must plan to cooperate by sending physicians and supplies to the bombed areas and by receiving evacuated patients.

Rescue teams and personnel of the treatment units would not, in all likelihood, find the victims of an atomic disaster easy to handle.¹³ They probably would be stunned and bewildered. Also they might be anxious and grief-stricken, or even hostile. Hostility might reach the point of physical violence toward the rescuer at what might be interpreted as neglect of members of a victim's family in favor of other victims. It is, of course, obvious that medical supplies would have to be conserved. Vitally needed supplies and equipment ought not be depleted by ill-considered use on persons only slightly injured, or on those beyond medical aid.

In atomic attack the psychological factors would be increased because the populace would be unaware of the nature of the attack. In view of the psychological aspects of the problem, rescue personnel would require police power and weapons to enforce it. They would then also be empowered to prevent unauthorized use of vehicles in the disaster area and thus prevent interference with rescue operations. Pillage is, of course, a usual concomitant of disaster, and the measures mentioned would help prevent it.

Indoctrination programs should be instituted to reduce the psychological problems the rescuer probably would encounter. In the process of the indoctrination to prevent anxiety, consideration should be given to some of the misconceptions regarding the effects of irradiation. For example, contrary to the belief of some persons, acute radiation injury is not a communicable disease, nor does it cause the patient to be radioactive. Many people believe that it is possible for an object or person contaminated with radioactive material to render objects or persons in the immediate vicinity radioactive without actual contact. This is, of course, false, for contamination can only be the result of actual transfer of radioactive material from one object to another.

Cancer is thought to be an occasional sequel to periodic radiation exposure. There are little or no data to indicate an increased incidence of cancer among survivors of a single acute exposure, although it appears likely that the incidence of leukemia will be higher among the Japanese survivors than in the population as a whole.¹⁴ Cataracts of varying severity have appeared in Japanese survivors; but the incidence to date is low. Sterility was rare and transient, and the incidence of abnormal offspring did not increase.

Radiation exposure is commonly thought to result in impotence. This is, of course, false. Such a condition can result from emotional stress in predisposed persons, and such stress is quite possible in the bombed population. However, the incidence of this condition among Japanese survivors was very low.

Education of the public, and proper indoctrination of rescue teams, will go far to diminish the psychological stress and the resulting deleterious effects of it following an atomic burst.

THE INDIVIDUAL CASUALTY

Diagnosis

It has been emphasized that blast and burn casualties will constitute the main problem. Careful evaluation of the burned or otherwise injured patient will be necessary, but the diagnostic problems are not new. However, since acute radiation injury has not been observed by many American physicians, and since its manifestations are, for the most part, delayed, it will present a diagnostic and prognostic problem.^{7, 8} It is of value to decide what criteria are available to determine what persons have been irradiated, and to what degree.

Some information on dosage received can be gleaned from (1) the dosimeter reading, if available, and (2) the position of the person relative to the site of detonation. Dosimeters either on or in the vicinity of the individual will indicate the order of magnitude of dosage received. Knowledge of the position, if the kilotonnage of the bomb is known, will also permit estimation of dosage—a person in the open, 4,200 feet from the epicenter of a 20-kiloton bomb, would have received about 400 r, while a person at 5,200 feet would have received about 100 r. The size of the bomb can be approximated soon after the blast, and the distance-dose relationship should be available early.

Such estimations of dosage are excellent as a basis for over-all planning. As an accurate index of the probable fate of an *individual*, however, such estimations at present are of limited value. Dosimeters indicate the dose received by the instrument, which may be only a rough approximation of the effective dose received by the person in question. The position of an individual is obviously but a rough index of dosage received. Neither the dosimeter reading nor position take adequate account of the energy of the radiation, nor the degree of partial or total body-shielding of the individual; and, most important, the extreme degree of variation in response of individuals. Hence, neither the dosimeter readings nor position data should be used *by themselves* as the final index for triage, therapy, or prognosis. That is, there may be a vast difference between the presumptive diagnosis resulting from physical data and the diagnosis resulting from an over-all clinical evaluation of the patient's status.

The best appraisal of exposure, and degree of exposure is, as with any disease, an accurate clinical evaluation by the physician. A thorough evaluation can result only from a history (which includes any physical estimates of dose), a physical examination, and pertinent laboratory data. Symptoms suggestive of radiation injury include vomiting on the day of the bombing, oropharyngeal lesions, and hemorrhagic manifestations other than cutaneous purpura. Specific symptoms include epilation and purpura. The presence or absence of the symptoms indicated previously

(anorexia, malaise, diarrhea, melena, etc.) are of considerable value in appraising the status of a patient.

The degree of exposure can be estimated fairly accurately by the tempo of the disease. For instance, if vomiting on the day of the bombing proceeds without remission to other symptoms of the disease, exposure probably was severe and the prognosis is grave. If vomiting on the day of the bombing is followed by a remission, or if vomiting is absent entirely, the probability of severe exposure is less and recovery is likely.

The clinical laboratory can provide data of inestimable value in early diagnosis and prognosis. Pronounced leukopenia is indicative of severe exposure, and a total leukocyte count of below 2,000 per cubic mm. of blood in the first week is indicative of very severe prognosis. A total lymphocyte count of less than 800 per cu. mm. two days after exposure is presumptive evidence of severe radiation exposure.¹¹ A significantly lowered absolute lymphocyte count within 24 hours is quite suggestive of such exposure.

Platelet counts remain stable for several days following exposure; however, a greatly decreased platelet count one week after exposure is indicative of severe overexposure. Anemia appears late, as much as two to three weeks after exposure; hence the erythrocyte count is not a good early index of damage. However, an increase in reticulocytes any time after exposure is a very good prognostic sign.

Treatment

It remains to examine what can be done for the patient with acute radiation injury. The treatment of this disease is at this time entirely symptomatic and supportive, and physicians in general have had no clinical experience with acute radiation injury. Nevertheless, intelligent care, even if only of a supportive nature, would salvage a great number who might otherwise die.

The severely irradiated patient should be put at complete bed rest as soon as possible after exposure. It has been shown with laboratory animals that repeated vigorous exercise considerably increases mortality.⁹

The use of antibiotics in the irradiated patient would probably be of definite value. Antibiotic therapy should probably await a clear-cut clinical indication for it. However, optimum dose schedules for man must await further clinical experience. Large doses probably would be needed to offset the lack of immune responses of the irradiated subject.

The value of transfusions in radiation injury is in doubt at this time. However, should transfusions be used they probably would not need be started until anemia was present, generally two weeks or more after exposure.

Adequate fluids and salts should be given to replace losses due to vomiting and diarrhea. The oral or rectal route should be used if possible; needle punctures would be hazardous because of the bleeding tendencies and the decreased resistance to infection of the irradiated patient.

The bleeding tendencies might be treated with protamine or toluidine blue. These are believed to combine with the heparin-like substances said to be present in the blood in excess concentration. Neither this mechanism of the hemorrhage nor the efficacy of this type of treatment has been established in man.

Vitamins C, P, rutin and various flavinoids have been suggested as being of some value in preventing capillary fragility. These are of doubtful value in preventing the hemorrhagic effects in the irradiated patient.

Oxygen may be efficacious in alleviating the tissue anoxia, which may be present in radiation injury.

A liquid diet should be used early. Later, a smooth diet should be given, since injured gastrointestinal tract mucosa will not tolerate even mild trauma.

Little benefit may be expected from iron supplements and folic acid. Several prophylactic agents such as cysteine, glutathione, and substances producing histotoxic anoxia (cyanide, thiouracil, etc.) have been found to be of value in animals if administered prior to irradiation. No such drugs have been tried for whole body irradiation in man, and at present there is no prophylactic agent of practical value for use in human beings.

U. S. Naval Radiological Defense Laboratory, San Francisco.

Note: The California Civil Defense Authority created a State Radiological Safety Evaluation Board after this article was accepted for publication. This board in turn has created a series of Regional and Area Evaluation Boards which are now in process of organization and rehearsal. These boards will be composed of radiologists and other persons familiar with radiation hazards, and will work in cooperation with local fire and police departments in the event of a bomb strike. Their work will be integrated with the Radiological Defense Division of the State Civil Defense Program.

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CANCER

Edited by JOHN C. HAWK, JR., M.D., Charleston, S. C.

BRAIN TUMORS

A Clinical Survey

BERNARD E. FERRARA, M. D.

AND

FREDERICK E. KREDEL, M. D.

Intracranial tumors are largely benign as regards their histo-architecture but are anatomically malignant in relation to their threat to the life of the patient. Because of this fact and the lack of any other broad program for the care of these patients, the Cancer Clinic of the Medical College of South Carolina has accepted for treatment all cases of suspected brain tumors. The present report is a review of brain tumor cases from the files of both the Cancer Clinic and the Roper Hospital. The inclusion of private patients in the Roper Hospital has limited the opportunity for follow-up data. Cases dying of disseminated carcinoma with intracranial involvement are not likely to be revealed in a search of hospital records where the primary cancer only is indexed. Pituitary adenomas, diagnosed by office examination plus radiography of the skull, and treated by x-ray without hospitalization, may well escape inclusion in this statistical survey. Nevertheless we have attempted to review all cases indexed in the files of the Cancer Clinic and the Roper Hospital during the ten year period between January 1, 1940 and January 31, 1949. Only those cases which were considered to have definite evidence of intracranial neoplasm were included in this analysis, a total of 72 cases. As shown in Table I, 40 were verified histologically, while in 26 cases there was no histological verification. Six cases are listed only as probable brain tumors because they either refused complete diagnostic studies and

treatment or were referred to another institution.

TABLE I

Histologically verified tumors	40
Cases not verified histologically	26
Probable brain tumors	6
Total	72

Table II presents a classification of the tumors with the histologically verified tumors listed according to the proven microscopic diagnosis, and the unverified tumors listed according to the most likely diagnosis based on the complete clinical picture. It will be noted that 72% of the histologically verified tumors fell in the glioma group.

TABLE II
CLASSIFICATION

Histologically Verified Tumors

I. Glioma	
Glioblastoma multiforme	12
Astrocytoma	3
Astroblastoma	3
Spongioblastoma multiforme	3
Spongioblastoma unipolare	1
Medulloblastoma	1
Ependymoma	1
Ependymboblastoma	1
Pincaloma	3
Mixed glioma	1
II. Meningioma	3
III. Tumor of Hypophysis	1
IV. Tumor of Blood Vessels	1
V. Acoustic Neuroma	1
VI. Congenital Tumor—Craniopharyngioma	2
VII. Metastatic Tumor	2
VIII. Granuloma—Tuberculoma	1
Total	40

From the Department of Surgery and the Cancer Clinic, the Medical College of South Carolina, and the Roper Hospital, Charleston 16, South Carolina.

This study was supported in part by a cancer training grant from the National Cancer Institute of the National Institute of Health, U. S. Public Health Service.

Unverified Tumors

Astrocytoma	3
Pinealoma	3
Pituitary Adenoma	5
Metastatic Carcinoma	1
Tumor of Blood Vessels	2
Meningioma	1
Brain Tumor (Probable Glioblastoma)	11
Total	26

Probable Tumors

X-ray therapy was given postoperatively. The child's family subsequently moved to another city. Six months postoperatively it was learned that the child was rapidly becoming worse and that another course of x-ray therapy was contemplated. The other two cases were in adults. In one, a 47 year old white female, only a suboccipital decompression was done at operation because of the patient's poor general condition. She died two days postoperatively and autopsy revealed a tumor mass in the left cerebellar tonsil which on histological section was an ependymoma. The second patient, a 56 year old white male, was operated upon because of signs of a cerebellar tumor. Death occurred on the twenty-third postoperative day, and at autopsy a large tumor mass was found in the right cerebellar hemisphere, histologically similar to a bronchogenic carcinoma found originating from the left upper lobe bronchus. Among the histologically unverified tumors there were three cerebellar tumors in adults and one in a child.

In Table III is tabulated the incidence of cases in three arbitrary age groups, listing patients as adults, adolescents, or children. The probable brain tumors are included with the unverified cases in this tabulation.

TABLE III
INCIDENCE IN AGE GROUPS

	Adults	Adolescents	Children	Total
Verified	32	0	8	40
Unverified	25	5	2	32
Total	57	5	10	72

A tabulation of the location of the tumors within the brain is given in Table IV.

TABLE IV
LOCATION

	Verified	Unverified
Cerebral Hemispheres		
Frontal Lobe	13	3
Temporal Lobe	9	4
Parietal Lobe	9	6
Occipital Lobe	3	2
Diffuse Involvement of a Hemisphere	1	4
Cerebellum	3	4
Third Ventricle	7	9
Brain stem	3	1

Anatomically, in several cases at operation and/or autopsy, the tumor was located in more than one contiguous lobe, thus accounting for the listing of more locations than cases. In one case, a 61 year old white male was suspected clinically of having a cerebrovascular accident, but was found at autopsy to have a tumor mass in the left frontal lobe and another in the right occipital lobe, both histologically similar and identified as glioblastoma multiforme. As anticipated, a majority of the tumors involved the cerebral hemispheres.

Among the histologically proven tumors there were three of the cerebellum, only one of which occurred in a child, a 4 year old white boy. This was a medulloblastoma. The tumor was unencapsulated at operation and the excision was thought to be incomplete.

SYMPTOMS

The incidence of various symptoms in this group of cases is shown in Table V. The symptoms are those of increased intracranial pressure and those produced by the effects of the tumor in its particular anatomical location.

TABLE V
SYMPTOMS AND THEIR INCIDENCE

Headache	55
Visual disturbances	38
Vomiting	35
Motor disability	33
Vertigo	20
Convulsions	15
Ataxia	15
Mental aberrations	14
Loss of consciousness	12
Sensory disability	11
Incontinence—bladder and rectum	10
Tinnitus	6
Personality changes	5
Aphasia	5
Impairment of hearing	4
Lethargy and somnolence	4
Weight loss	4
Fever	3
Insomnia	1
Visual hallucinations	1
Auditory hallucinations	1
Loss of libido	1

The time interval between the onset of symptoms and the seeking of medical advice varied from seven

days to 14½ years, averaging 11 months. Two cases were admitted because of complaints referable to other systems and the diagnosis of brain tumor was established during a diagnostic work-up.

Diagnostic procedures employed included the following:

- Neurological examination
- Skull x-rays
- Visual field examination
- Electro-encephalogram
- Lumbar puncture
- Pneumo-encephalogram
- Ventriculogram

TREATMENT AND RESULTS

As shown in Table VI, the treated cases can be divided into three groups: first, the largest group, those cases treated by surgery alone; second, those treated by surgery and roentgen therapy combined; and finally, those treated by roentgen therapy alone.

TABLE VI
TREATMENT

	Cases	Known to Have Died
Cases treated by surgery alone	34)	
Cases treated by surgery combined with x-ray	12)	46 32
Cases treated with x-ray alone	7	4
Cases receiving no treatment	19	11
	—	—
Total	72	47

Major surgical procedures were performed on 46 of the total of 72 cases. Fifty-eight surgical procedures were accomplished on these 46 patients and these are tabulated in Table VII. These figures do not include trephines which were done for diagnostic purposes. Of the 36 cases in which craniotomy was performed primarily, decompression was carried out at the same time in 25 cases.

TABLE VII
SURGICAL PROCEDURES

Decompression alone	5
Decompression with biopsy or aspiration of cysts	6
Craniotomy with total or partial excision of tumor	36
Decompression first, followed at interval by craniotomy (3 cases)	6
Tantalum cranioplasty	2
Excision cortical scar following craniotomy	3
	—
Total surgical procedures	58

In the 46 cases which had operative procedures, there were 16 deaths in the immediate postoperative period, taking two weeks as an arbitrary interval, and

four deaths in the hospital at intervals longer than two weeks postoperatively. Follow-up data is not complete; however, the number of cases known to have died up to the present time is indicated in Table VI for each form of therapy.

The average survival time from the onset of symptoms to the time of death in those cases which were operated upon and subsequently died was one and a half years. In the total series of 72 cases, 47 deaths have thus far been recorded. The survival time from the onset of symptoms to death in the total of 47 deaths also averages one and a half years.

Twelve cases were treated by surgery in combination with roentgen therapy. The survival times are included with those treated by surgery alone, as the intervals did not vary appreciably.

Seven patients were treated with x-ray therapy alone. One of these was a 55 year old white male, diagnosed clinically as a case of craniopharyngioma, who died while being treated. Autopsy confirmed the diagnosis. Two interesting patients treated by x-ray alone were lost to follow-up. One, a 70 year old white female, had a pinealoma diagnosed by x-ray examination. The other, a 15 year old white female, with a history of convulsions for eight months, had a port-wine hemangioma of the face at birth. Her visual fields were constricted bilaterally and x-ray findings were indicative of an hemangioma of the left occipital lobe. The other four patients treated by roentgen therapy alone had pituitary tumors, all diagnosed by x-ray examination. One was a 24 year old colored male, with a two-year history of blindness, loss of libido and headache. On physical examination he had small external genitalia and sparse hair over the body. He was treated with x-ray therapy but died one week after completion of treatment. At autopsy, a large chromophobe adenoma of the pituitary was found.

Nineteen patients in the series received no definitive therapy in this institution. Six were those previously mentioned who were listed as having probable brain tumors, but who either refused diagnostic procedures and treatment or were referred elsewhere. Of these, one later returned after having had a craniotomy at another institution and died in this hospital. No histological diagnosis had been made at craniotomy and autopsy was not obtained. Among the remaining 13, there were two patients with pituitary adenomas diagnosed by x-ray who received no treatment. One of these patients, admitted because of cerebral concussion, had no symptoms of tumor, but by x-ray was shown to have marked erosion of the posterior clinoid processes and the posterior wall of the right orbit; treatment was refused. There were two untreated cases of histologically proven pinealoma. One was that of a 45 year old colored female, admitted originally for regulation of diabetes. Because of findings consistent with a brain tumor, ventriculograms were obtained. She died the following day and autopsy re-

vealed the diagnosis. The second was that of a 42 year old colored male who died the day after admission, and who was believed clinically to have a cerebellar tumor. At autopsy a pinealoma was found with an extension over the vermis of the cerebellum.

Another untreated case was that of an 11 year old colored male who was semistuporous on admission, with a stiff neck and probable papilledema. A lumbar puncture was done and the cerebrospinal fluid pressure found to be tremendously increased. Death occurred five hours after admission. At autopsy a cranio-pharyngioma was found with internal hydrocephalus and a marked pressure cone.

Three cases of glioblastoma multiforme received no treatment. One patient, suspected clinically of having a thrombosis of the inferior cerebellar artery with signs of cerebellar pathology, at autopsy was found to have a glioblastoma of the right frontal lobe with hemorrhage into the pons and rupture into the fourth ventricle. A second patient was suspected clinically of having a cerebrovascular accident. A third patient was admitted six days after having been hit on the head and about the body with a beer bottle. His complaints were drowsiness and headache and he was observed for possibility of head injury or hematoma. Glioblastoma multiforme of the right frontal and parietal lobes was found at autopsy.

A 24 year old colored female was transferred from another hospital because of the possibility of poliomyelitis and died one hour after admission. Post-mortem revealed an astroblastoma of the left frontal lobe.

A 45 year old colored female was suspected of having a cerebral hemorrhage. A large spongi-

blastoma multiforme of the left parietal and temporal lobes with hemorrhage into the ventricle was found at autopsy.

An 8 year old white male, stuporous on admission, was deemed inoperable. Spongioblastoma unipolare of the pons was found at autopsy.

Two other patients, with obvious signs of brain tumor, were deemed inoperable and died, but no autopsy was performed.

SUMMARY AND CONCLUSIONS

Intracranial tumors as a group have carried a rather poor prognosis in this series. We have had a high incidence of glioblastoma and of other histologically aggressive types of glioma. Palliative decompression in these cases has been useful in relieving the patient from the agonizing symptoms of intracranial hypertension. It is our impression that x-ray treatment has afforded a worthwhile extension of postoperative survival in some cases. In one instance x-ray plus repeated operation resulted in a seven year span of useful existence after the first craniotomy.

X-ray alone has been the treatment of choice for pituitary adenomas. Decompression followed by x-ray has produced excellent results in several cases of pinealoma. Cystic lesions, treated by aspiration with or without removal of the mural nodule, have done well.

The Medical College plans to develop in the near future a separate division of Neurological Surgery. While this specialty has made remarkable advances in many directions, the end results from the treatment of brain tumors leave much to be desired the country over. Newer developments, such as the use of radioactive isotopes, may improve the present rather dismal picture.

SOUTH CAROLINA PEDIATRIC SOCIETY

The annual business meeting of the South Carolina Pediatric Society will be held at the Murphy Gnest House, 2300 N. Ocean Boulevard, Myrtle Beach, Wednesday, May 14, 6:00 P. M. This will be followed by a social hour (courtesy Mead Johnson and Co.), and dinner (dutch), for members and their wives.

**PROGRAM, ANNUAL MEETING
SOUTH CAROLINA MEDICAL ASSOCIATION
OCEAN FOREST HOTEL, MYRTLE BEACH**

MONDAY, MAY 12: Meeting of the Council

TUESDAY, MAY 13: House of Delegates

10:00 A. M.—Call to order

Report of Credentials Committee

Remarks by the President

Remarks by the President-Elect

Presentations of resolutions and recommendations (Written reports of officers and committee chairmen will have been sent to all delegates and will not be read before the House.)

Chairman of the Council

The Secretary

The Business Manager and Director of Public Relations

The Treasurer

The Editor of *The Journal*

The Chairman, Executive Committee, State Board of Health

Other Committee Chairmen

Recalling of proposed amendments to Constitution from the table

Presentation of resolutions by Delegates

12:30 P. M.—(Special order) Annual meeting, The Corporation South Carolina Medical Care Plan

1:30 P. M.—Recess until 9:00 A. M.

3:00 P. M.—Meetings of Reference Committees

(All members of the Association are urged to appear before the committees considering matters in which they are interested.)

WEDNESDAY, MAY 14: Recessed meeting House of Delegates

9:00 A. M.—Call to order

Reports of reference committees

12:30 P. M.—(Special order) Annual Elections

1:30 P. M.—Sine die adjournment

2:30 P. M.—Scientific Session

5:15 P. M.—Adjournment

8:30 P. M.—Entertainment in The Patio

THURSDAY, MAY 15:

9:00 A. M.—Scientific Session

12:30 P. M.—Luncheon Recess

Alumni Luncheon

2:30 P. M.—Scientific Session

4:45 P. M.—Adjournment

6:00 P. M.—Cocktails in the Ball Room

7:00 P. M.—Annual Banquet and installation of the President

Dr. John McSween, After-Dinner Speaker

THE SCIENTIFIC PROGRAM**WEDNESDAY, MAY 14**

- 2:30 P. M.—“Humidification in Medical Practice”—Dr. S. F. Ravenel, Greensboro, N. C.
- 3:00 P. M.—“Accidental Poisoning in Children”—Dr. Julian P. Price, Florence
- 3:20 P. M.—Discussion
- 3:25 P. M.—“Prevention of Prematurity”—Dr. Frank B. Geibel, Columbia
- 3:35 P. M.—“Pathology of Prematurity”—Dr. H. R. Pratt-Thomas, Associate Professor of Pathology, Medical College of South Carolina, Charleston
- 3:45 P. M.—Discussion
- 4:00 P. M.—Intermission
- 4:15 P. M.—“Idiopathic Pericarditis”—Dr. Izard Josey, Columbia
- 4:35 P. M.—“The Mechanisms of Acid Base Balance of Clinical Significance”—Dr. L. C. Reid, Associate Professor of Physiology, New York University School of Medicine, and Professor of Experimental Surgery in the Postgraduate Medical School of New York University, New York
- 5:15 P. M.—Adjournment

THURSDAY, MAY 15

- 9:00 A. M.—Memorial Service—Dr. Paul K. Switzer, Union
- 9:15 A. M.—Symposium on Anesthesia
1. “Spinal Anesthesia”—Dr. W. T. Lemmon, Philadelphia
 2. “Pentothal and Curare”—Dr. Chas. H. Poole, Spartanburg
 3. “Nerve Blocks for Diagnostic and Anesthetic Purposes”—Dr. R. E. Edmondson, Anderson
 4. “Inhalation Anesthesia”—Dr. J. M. Brown, Associate Professor of Surgery (Anesthesiology), Medical College of South Carolina, Charleston
- 10:45 A. M.—Discussion
- 11:00 A. M.—“Is the Medical Profession in the Process of Being Regimented?” — Dr. J. Heyward Gibbes, Columbia
- 11:30 A. M.—“The Physiologic Basis for Clinical Use of ACTH and Cortisone”—Dr. Hugh Smith, Jr., Greenville
- 11:50 A. M.—Discussion
- 12:00 N.—“Use and Abuse of Barbiturates”—Dr. W. G. Moorehouse, State Hospital, Columbia
- 12:20 P. M.—Discussion
- 12:30 P. M.—Luncheon Recess
- 2:30 P. M.—“Electroshock Therapy and Lobotomy Program in The State Hospital”—Drs. J. E. Freed and Edw. M. Burn, Columbia
- 3:00 P. M.—“The Role of the Kidney in Sodium and Potassium Excretion and Water Balance”—Dr. L. C. Reid, New York
- 3:30 P. M.—(Special Order) Presentation of the Presidents of the Woman’s Auxiliaries of the South Carolina and American Medical Associations
- 3:45 P. M.—(Special Order) The President’s Address—Dr. J. Decherd Guess, Greenville
- 4:15 P. M.—“Acute Pancreatitis—the Diagnosis and Treatment”—Dr. Vince Moseley, Professor of Medicine, Medical College of South Carolina, Charleston
- 4:35 P. M.—Discussion
- 4:45 P. M.—Adjournment

The Journal of the South Carolina Medical Association

EDITOR: Julian P. Price

Florence, S. C.

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Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

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APRIL, 1952

HOUSE OF DELEGATES

Modeled after the type meeting held in the American Medical Association and many of the state medical associations, adapted to our own needs by our President, Dr. J. D. Guess, our House of Delegates will attempt a new style of meeting this year at Myrtle Beach. For the first time we will have several Reference Committees to which all reports and resolutions will be referred for full discussion before they are finally presented to the House for action.

The modus operandi will be as follows: As soon as the House has convened, the presiding officer will appoint the reference committees—varying from five to seven in number, with each composed of five members. As each report of a committee is read it will be referred immediately to one of the committees. The same procedure will prevail for any special resolutions. All of this will take place on Tuesday morning. On Tuesday afternoon, and during the evening if necessary, the Reference Committees will meet. Any member of the Association, whether he be a delegate or not, is entitled to appear before the committees to present his views upon any given subject or to listen to the general discussion. After all who wish to present their views have appeared, the committees will go into executive session and prepare their reports. These reports may endorse, reject, or modify the original resolutions.

On Wednesday morning the reports of the committees will be presented to the House in full session where further discussion may ensue before the members vote on accepting, rejecting, or amending the recommendations.

Through this method ample opportunity will be given to every member of the House and of the Association to present his views upon a given subject—and yet the time of the entire membership of the House will not be taken up with a discussion of every item. It is a thoroughly democratic procedure and allows for much more latitude in debate than did our older method of having each resolution acted upon when it was presented.

Following the meeting this year, the delegates will be in position to decide whether this newer method of procedure is preferable or whether it is desirable to return to our former method of conducting the meeting.

SPEAKER OF THE HOUSE

One of the changes which will be proposed in the revision of our Constitution and By-Laws this year will be the creation of a new office—that of a Speaker of the House of Delegates. This is nothing new in medical organizations since most large organizations have an officer of this type, but it would be new for South Carolina.

It would be the duty of the Speaker to preside at all business sessions of the House of Delegates. He would appoint the reference committees, see that the business of the House is run according to parliamentary law and according to our own Constitution and By-Laws, he would refrain from participating in the discussion, and would vote only in case of a tie.

The advantage in having such an elected individual is that it would insure the House of having a presiding officer who was well versed in the handling of a meeting. Of necessity, he would have to be a good parliamentarian and one who was thoroughly grounded in the provisions of our own Constitution and By-Laws.

The disadvantage would be that it would deprive the President of the Association from presiding at the meeting—a privilege which some presidents might hold quite dear.

It will be up to the members of the House of Delegates to make the decision at this next annual meeting.

PAST-PRESIDENTS IN THE HOUSE OF DELEGATES

A question which we have heard discussed considerably this year and one which will be presented to the House of Delegates for decision at the coming

meeting in May will be "Should the past-presidents of the Association be ex officio members of the House of Delegates?" This custom has prevailed up to the present. Should it be modified or discontinued?

Without taking sides in the issue, we would like to present some of the arguments which we have heard expressed.

Those who favor allowing all past-presidents to continue to serve as members of the House of Delegates argue that these men have served the Association in an official capacity, they know a great deal of the workings of the Association, they are men of mature judgment, they are not interested in any personal advancement in the Association, and they serve as a source of knowledge and balanced judgment which the House needs.

Those who favor discontinuing the present custom of having past-presidents in the House argue that the House is a democratic body composed of elected delegates and it is unwise to have as many as twenty percent of the membership composed of men who are not elected and who are not responsible to their county societies for their actions, that the past-presidents through their long tenure of office and know-how tend to dominate the actions and activities of the House, that the House tends to become top heavy with older men with older ideas and thus puts a damper upon the younger men with their more fresh and vigorous ideas, that the past-presidents have had their day and that they should be glad to turn the reins over to others.

To continue or not to continue to have past-presidents in the House of Delegates—that is a question which will be discussed fully at our coming meeting. It would be well for the delegates to discuss the matter with their colleagues before coming to the meeting so that they will be in a position to vote more intelligently.

SOUTHERN PEDIATRIC SEMINAR

The thirty second session of the Southern Pediatric Seminar will be held in Saluda, N. C. from July 14 to July 26. From a small beginning this Seminar has now grown into what many have declared to be the best post-graduate course in pediatrics in the country. Last year for the first a third week was added devoted to instruction in obstetrics.

For those who want to find out what is new in pediatrics and obstetrics, for those who need to brush up on these two fields of medical practice, this course offers a unique opportunity. Those who desire more information are asked to communicate with Dr. D. L. Smith, Spartanburg.

A. M. A. ANNUAL MEETING

The annual meeting of the American Medical Association will be held in Chicago, June 9-13.

Chicago is not far from South Carolina and we

would strongly urge that as many of our members as possible plan to attend the meeting this year. It is our feeling that every physician owes it to himself to attend at least one of these annual meetings and the meeting this June affords an excellent opportunity to do this. It not only gives one a mass of scientific information but also affords the privilege of meeting colleagues from every part of the country. It lifts one out of the small confines of his own practice and gives him a view of what is being done over the entire country. It is a stimulus which each of us needs to keep from getting into a rut.

If a sufficient number are interested it might be possible to secure a special pullman car in which all could go together. Those who are interested are asked to communicate with Mr. M. L. Meadors or the editor, immediately.

DEATHS

SAMUEL JACOBS SUMMERS

Dr. Samuel Jacobs Summers, 83, Cameron physician and farmer, died on February 26th, at his home. He had been in declining health for the past two years.

Dr. Summers attended the University of South Carolina and received his medical degree from the University of Maryland. He began the practice of medicine in Cameron with his father and practiced there until his health failed. In addition to his practice of medicine and various farming interests, he also had served two terms as senator from Calhoun County.

Dr. Summers is survived by his widow, four daughters and three sons.

THOMAS N. DULIN

Dr. Thomas N. Dulin, 81 died at his home near Clover on March 7th after several years of declining health.

Dr. Dulin was graduated from the Atlanta Medical College in 1892 and had practiced in his community for more than fifty years. He was an honorary member of the South Carolina Medical Association.

He is survived by a son and a daughter.

HAWKINS KING JENKINS

Dr. Hawkins King Jenkins, staff physician at the South Carolina Sanatorium at State Park died at the Columbia Hospital on the morning of March 16, at the age of 59.

A native of Charleston, Dr. Jenkins received his medical training at the Medical College of South Carolina. (Class of 1919). He had been at State Park for the past ten years.

Surviving Dr. Jenkins are his widow and two daughters.

NEWS ITEMS

BRODIE C. NALLE LECTURE

The first Brodie C. Nalle Lecture was delivered by Dr. Emil Novak of Baltimore, Maryland, on April 14, 1950, on "Indications, Limitations and Hazards of Endocrine Therapy in Gynecology." The second lecture was delivered by Dr. Samuel A. Cosgrove of Jersey City, New Jersey on April 27, 1951, on the subject, "The Clinical Management of the Toxemias of Pregnancy."

The third Brodie C. Nalle Lecture will be presented by the Brodie C. Nalle Fund of The Nalle Clinic Foundation on Friday, April 25, 1952, at 8:00 P. M. in the Ballroom of the Hotel Charlotte, Charlotte, North Carolina. The Ballroom provides a much larger space than has been available for the last two lectures, and seating should certainly be adequate and comfortable.

The speaker for this lecture will be Dr. Richard W. TeLinde of Johns Hopkins University School of Medicine, Baltimore, Maryland. His subject will be:

CARCINOMA OF THE CERVIX: RECENT ADVANCES IN DIAGNOSIS AND TREATMENT

The Eighteenth Annual Meeting of the American College of Chest Physicians will be held at the Congress Hotel, Chicago, Illinois, June 5 through 8, 1952. A scientific program covering all recent developments in the treatment of heart and lung disease is being arranged.

The Board of Examiners of the American College of Chest Physicians announces that the next oral and written examinations for Fellowship will be held in Chicago on June 5, 1952. Candidates for Fellowship in the College who wish to take the examinations should contact the Executive Secretary, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

Dr. R. Kyle Brown of Greenville serves as Governor of the College for South Carolina.

Mount Sinai Hospital of Greater Miami announces its Second Annual Seminar on Recent Advances in Diagnosis and Treatment to be held at the Delano Hotel, Miami Beach, May 22nd, 23rd, and 24th, 1952.

Eight outstanding lecturers from various parts of the United States will conduct the Seminar. The speakers include:

Dr. Joseph B. Kirsner, University of Chicago
Dr. Daniel C. Darrow, Yale University School of Medicine
Dr. Rachmiel Levine, Michael Reese Hospital
Dr. William Dameshek, Tufts Medical College
Dr. Robert Elman, Washington University School of Medicine
Dr. James H. Means, Harvard University
Dr. D. M. Bergenstal, University of Chicago
Dr. J. William Hinton, New York University

The subjects to be presented are:

Recent Advances in the Treatment of G. I. Diseases
Recent Advances in the Diagnosis and Treatment of Electrolyte Disturbances
Treatment of Diabetes
Recent Advances in Hematology
Recent Advances in Surgery
Recent Advances in Thyroidology

Registration fee is \$20.00. There will be a banquet to which the wives are invited. Attendance at the banquet is optional. For interns and residents there is no registration fee.

Dr. John F. McLaughlin, Jr., has opened offices for the practice of general medicine at Meggett, S. C.

Dr. John K. Webb of Greenville was elected Vice President of the Tri-State Medical Association at the meeting held recently in Roanoke.

Dr. Robert Sumner of Rock Hill has been elected president of the York County Medical Society for the ensuing year. Dr. Carl P. Parker of Clover was elected vice president and Dr. Sam Lowe of Rock Hill, secretary-treasurer.

WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. K. D. Shealy, Columbia, S. C.

Publicity Secretary: Mrs. Weston Cook, Columbia, S. C.

TENTATIVE PROGRAM of the WOMAN'S AUXILIARY to the SOUTH CAROLINA MEDICAL ASSOCIATION Twenty-seventh Annual Convention Ocean Forest Hotel Myrtle Beach, South Carolina May 13, 14, 15

MONDAY, MAY 12—Auxiliary Committee Meeting with Council of Medical Association
President—Mrs. Kirby D. Shealy, Columbia
Pres.-Elect—Mrs. W. O. Whetsell, Orangeburg
Treasurer—Mrs. David A. Wilson, Greenville
TUESDAY, MAY 13—Finance Committee—
Mrs. J. L. Sanders, Greenville
Jane Todd Crawford Mem. Loan Fund—
Mrs. Alton G. Brown, Rock Hill

Student Loan Fund—
Mrs. Vanece W. Brabham, Sr., Orangeburg
WEDNESDAY, MAY 14—A. M. Executive Board Meeting. Mrs. Kirby D. Shealy, president, presiding. Mrs. Richard F. Stover, Miami, Fla., Pres.-Elect Woman's Aux. to the Southern Medical Association, speaker.
P. M. Tea honoring Mrs. Harold F. Wahlquist, Minneapolis, Minn. President Woman's Aux. to the American Medical Association, and Mrs. Richard F. Stover, Dunes Country Club. All women attending convention invited.
THURSDAY, MAY 15—A. M. House of Delegates. Mrs. Kirby D. Shealy, President, presiding.
A. M. Program Meeting. Mrs. Harold F. Wahlquist, speaker.
A. M. Post Convention Board Meeting. Mrs. W. O. Whetsell, President, presiding.

CORRESPONDENCE

Dr. J. P. Price, Editor
Journal of the S. C. Medical Association
Florence, South Carolina
Dear Dr. Price:

The Board of Trustees of the Crippled Children Society of South Carolina again requests your assistance. Our 1952 Easter Seal campaign begins March 13 and continues until April 13.

Our Society provides services that supplement and extend but do not duplicate the work of other private or public agencies.

You will be interested to know that 91.7% of all Easter Seal funds raised in South Carolina stays in our state to assist our own handicapped persons.

Our state project is the cerebral palsy program. Over

409 appointments have been made for our cerebral palsy clinics alone during the past year.

County societies provide braces, special education, transportation to clinics and other needed services.

Please assist us by running an article in your magazine during the Easter Seal Campaign. Will you use a mat or electro? Enclosed is a postal card. Please check the material you prefer and return the card to our state office so that we may have it sent to you.

Thank you for helping us to lend a helping hand to crippled children and adults.

Sincerely yours,
C. W. Griffith
President

THE TEN POINT PROGRAM

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

1952 DUES PAYABLE

All members who have not paid the State Association dues for the year 1952 are reminded that these dues were payable January 1st, and that their payment is a requisite for membership in good standing and registration at the annual meeting. The secretaries of county societies are reminded that the By-Laws of the Association, Chapter IX, Section 11, require that dues of the members be remitted to the State Treasurer before April 1st. A number of the county societies have already paid their dues and those of others are coming in. Of course, dues will be accepted up to the date of the annual meeting or at the meeting. The entry and proper recording of information relative to the payment of the dues and preparation of membership cards, however, entail considerable work and with all of the other preparations necessary to be made immediately previous to the annual meeting, payment as far as possible in advance will expedite the handling of the details, and will be greatly appreciated. The necessity of collecting dues and preparation of membership cards at the time of registration delays the procedure considerably.

THE 1952 DIRECTORY

As this goes to press the proof of the 1952 Directory is being checked and it is expected that the completed Directories will have been mailed to all members of the Association well in advance of the appearance of this issue of the Journal.

Because of the large number of new members and the very extensive increase in the amount of work in the administrative office, as the result of the necessity of collecting, tabulating and remitting dues of the

American Medical Association, as well as the State Association, during the past year, completion of the data for the Directory was delayed a few weeks longer than had been anticipated.

The new Directory contains the names of 1194 members of the South Carolina Medical Association. Practically all of these are listed twice, first in the alphabetical section and again in the geographical section where the listing is by towns and cities.

Of this number 144 are Honorary Fellows and are so indicated. 34 are in active service with the Armed Forces of the country and these are indicated by the letter (S) following their names. As in the past, the Directory contains, following the name of each physician, in the alphabetical section, the year of his birth, year of graduation from medical school and the type of his medical practice. All changes of address, concerning which the office had information, up to the very day of the return of the proof to the printer, were made, so that the Directory carries as accurately as it was possible to do so, the business addresses of the members of the Association.

Each member is entitled to one copy of the Directory without charge, the expense having been paid from dues and Journal subscriptions. Additional copies may be obtained from the Florence office at the price of \$.50 each to members of the Association, and \$1.00 each to non-members of the Association.

BLUE SHIELD PREPARES TO OFFER MEDICAL BENEFITS

For some time the Board of Directors of the South Carolina Medical Care (Blue Shield) Plan have been studying the advisability and possibility of adding medical services in the hospital, to the benefits provided subscribers and their dependents under the Blue

Shield contract. At the regular quarterly meeting on March 23rd, the Board adopted the form of a proposed contract providing for medical benefits. The new provisions must be approved from an actuarial standpoint on the basis of the wide experience of other plans offering the same types of service, and by the Insurance Department of the State of South Carolina. From the inquiry which has been made by the Executive Director and the Actuarial Committee of the Board of Directors, however, it is believed that approval from both those sources is highly probable and that the medical benefits can be made effective within the very near future.

The need for the addition of medical benefits has long been felt, both from the standpoint of its effect in making the contract more attractive to the subscriber, and from the viewpoint of the participating physician. The Plan has been subjected to some criticism from time to time because it was alleged to have provided for the payment of fees only to surgeons. Actually, this is not true, since the Plan has at all times provided benefits for minor surgery, much of which is performed by general practitioners in the office, clinic or hospital, and likewise, has at all times provided obstetrical benefits, the major portion of obstetrical service, at least in the small communities, being performed by general practitioners. The pediatricians and internists are perhaps among those who have had least opportunity to participate.

On the other hand, it has been the wish of the officials of the Plan ever since its beginning, and this was announced at the time, to add medical benefits as soon as the financial stricture would permit. It is a favorable commentary on the progress and development of the Plan in the two years of its existence that apparently the time has now arrived when such benefits can be added to the provisions of the contract.

Under the terms of the new contract which has been approved by the Board, the Plan will pay the participating physician for medical services, the amount of his regular charge, not exceeding, however, \$4.00 per day, for each day on which the physician visited his patient while in the hospital. The payments will not begin until the third day of the patient's stay in the hospital and will be limited to a maximum of 28 days in any one contract year. Medical, like surgical services, will not be covered during the first 12 months of membership for conditions known by the subscriber to exist on the date of application for membership.

Another addition made to the contract is the provision for payment for anesthesia when administered by a duly licensed doctor of medicine who is not the physician in charge of the case, and who is not an employee of the hospital. The Plan will pay up to \$15.00 for such services during any one hospital admission, for anesthesia administered in connection with surgical or obstetrical cases.

The amount of the concurrent raise in subscription rates is nominal in view of the extent of the additional benefits being offered. The new rates, if the contract is put into effect, will be, on a monthly basis, \$1.05

to the individual subscriber, \$2.35 for a widow or widower and unmarried children under nineteen, and \$2.75 for the family contract.

It will still be possible for subscribers to secure the old type contracts at the same rates, providing for only surgical and obstetrical benefits. No present subscribers, therefore, will be faced with the necessity of either paying a higher rate for his Blue Shield contract, or having it discontinued.

The progress of Blue Shield has been good. It has improved with the wider understanding and more substantial support of the Plan on the part of the doctors. With the additional benefits for medical service and anesthesia it would seem that the Plan now warrants, if it did not before, the whole-hearted support and co-operation of every member of the State Medical Association. Actually, more than 75 per cent of the membership are participating physicians in the Plan at the present time and a considerable number of others are receiving its benefits indirectly, through payment to their patients who are Blue Shield subscribers, of the fees for surgical and obstetrical services as provided in the fee schedule.

GRIEVANCE COMMITTEES

The Council on Medical Service of the American Medical Association in January, released a progress report on the development of Medical Society Grievance Committees. Last year a Committee headed by Dr. Roderick MacDonald, made its report to the House of Delegates, of the State Association recommending and setting forth a proposed plan of organization and conduct of such a committee in South Carolina. Action was deferred until the annual meeting this year, in order to afford an opportunity for the members of the Association to become better informed on the purpose, and method of operation of such committees. The matter is scheduled for action at the meeting in May. (The Columbia Medical Society, and possibly other County organizations, already have such a committee).

The January Report of the Council on Medical Service, contains valuable information, which, in view of the foregoing, should be of special interest to the members of the South Carolina Medical Association.

Following are extracts of some of the more important information contained in the report, copies of which will be furnished the members of the House of Delegates prior to the annual meeting.

"The House of Delegates at its Washington, D. C., meeting in December, 1949, adopted a resolution urging that all constituent medical associations have grievance committees to hear complaints from the public. Attention was drawn to the success of such committees already established, and it was proposed 'that all constituent associations adopt comparable programs.'

"It seems reasonable to assume that all of the constituent medical associations have in their Constitutions or By-Laws some provision for disciplining physicians violating the Principles of Medical Ethics.

Such provision would, of course, provide or at least allow for the hearing of complaints. This has probably been sufficient in past years, but with the medical profession moving positively into the public eye through its public education and public relations efforts more adequate steps for hearing and settling complaints from the public have become necessary.

"Today, the problem is not simply one of disciplining members but is one of improving relations with the public, of clarifying misunderstandings, of adjusting differences so that individual physicians and the profession itself may continue to retain the confidence of the American people. It is in accomplishing these objectives that grievance committees, properly handled, can be of most assistance. . . .

"In December, 1950, the Council on Medical Service issued a report on 'Medical Society Grievance Committees—Their Development and Function.' At that time the Council listed 34 constituent medical associations as having such committees. A little more than a year later the number of grievance committees has increased to 42, including committees in the District of Columbia and Hawaii. In addition, 4 state associations are considering the establishment of such committees, leaving but 4 state associations without committees either in operation or under consideration. . . .

"New York, North Dakota, Oregon, and South Carolina are reported to be considering the establishment of grievance committees.

"Additional data are available on two of these states: In New York, the state association not only is considering the creation of a state committee but also has made a written recommendation to each component society that it set up a local committee to handle grievances.

"In South Carolina, a planning committee has set up proposed amendments to the society by-laws to establish a committee. These are being publicized to the members and will be voted upon in 1952. The committee proposed for South Carolina would consist of the 5 immediate past presidents of the association and whatever members the Council sees fit to add. The committee would be of the grand jury type, not the judicial; it would supervise and recommend action, prefer and prosecute charges against the members. No member of the committee would act on a case from his own component society. The committee would accept both verbal and written complaints and would have the power to require the presence of any member of the society before its investigating group. . . .

"It is apparent that the question of grievance committees has been thoroughly considered by the great majority of the constituent associations. According to present reports, only 8 states have no program in operation to handle grievances on a state-wide basis, either through a special committee or through one of the associations' other committees. Of these 8, 1 has set up rules and regulations for such a committee and will vote on them in 1952; 3 are studying the question.

"Of the remaining 4 states, at least 3 have definitely considered the pros and cons of the issue; 2 have left the function in the hands of local societies, and one has decided to postpone formation of such a committee. Thus, so far as the state associations are concerned, the situation seems to be well in hand. . . .

"The most popular title is 'Grievance Committees', probably because the term appears in the resolution of the House of Delegates, in December 1949, urging that such committees be formed. However, many other names are in use and discussion continues concerning the possibility of a more appropriate title. The state-wide committee in Indiana, for example, changed its title from 'Grievance Committee' to 'Committee on Patient-Physician Relations' in December 1951. . . .

"The effectiveness (success) of any committee dealing with the delicate problems involved in settling complaints and grievances must necessarily depend to a great extent upon the personnel make-up of the committee: How many members? How long should the members serve? How should they be selected? These are important questions and are answered in part in the following paragraphs. . . .

"Jurisdiction: Grievance committees are usually authorized to hear and investigate complaints concerning the professional conduct and ethical deportment of individual physicians and to attempt amicable adjustment. For the most part their authority is limited to arbitration and does not include authority to discipline any physician. Where disciplinary action seems necessary all evidence is usually submitted to the Council or proper judicial authority.

"In a number of instances, however, the committee may not only refer the case to the proper judicial body, but may also prefer charges and prosecute as well. In at least one state, the decision of the committee is final and is so understood by both parties before a hearing is scheduled.

"In some states, component societies will not defend in court any member who does not abide by the committee's decision and, in at least one state, county committee members have testified in court for the patient in such a case.

"A few states limit the jurisdiction of their grievance committees to cases referred to them by the county medical societies, thereby acting as a sort of court of appeals. However, even in these states the committee may have original jurisdiction in cases of alleged grievances originating in areas where there are no county societies or where a county grievance committee is not functioning.

"Methods of Receiving Complaints: The majority of the grievance committees hear complaints from any source—physicians, organizations, or the general public, although a few prefer county societies to screen all cases first. The Welfare Committee of the Idaho association, for example, has stated that complaints can be handled more efficiently by the component society concerned and has recommended the formation of welfare committees by all component societies.

However, in most states complaints may be made direct to the state committee as well as through a local group.

"All committees accept written complaints, but only a few will also accept verbal complaints. Several committees are authorized to initiate investigation when they feel it is justified, regardless of whether or not a complaint has been filed.

"Reports and Records: Records of hearings are kept by almost all of the committees, and all make some reports on their activities to the state Council or House of Delegates or both. The records of committee hearings and meetings range all the way from complete transcripts to simple listings of the number of cases handled and settled. . . .

"About half of the state grievance committees reporting stated that the committee and its functions had been publicized. The extent of such publicity was limited in many instances to an announcement story at the time the committee was established. Others continue to publicize the existence of the committee as well as the results of the committee's activities. A few committees expressed the opinion that publicity would encourage ill-founded and nuisance complaints or might be looked upon as a defensive action on the part of the association. Some associations are still considering announcing the service generally, although it appears that a number of them would prefer to handle publicity through the local societies and thus, to some extent, screen the complaints received. Since many of these committees have been in operation only a short time, they have not yet decided whether they will issue annual reports to the public, although several are considering this method.

"The reasons for publicizing a grievance committee are perhaps best summed up by the Massachusetts Medical Society. When the first publicity was given to the Committee on Ethics and Discipline in June, 1950, the Society's News Letter explained the new policy with the following words: ' . . . Although this Committee has existed for some three-quarters of a century, the public has never been properly informed of the extent of our self-regulation. Publication of our Committee's existence is made in a sincere effort to improve our relations as a profession with the public . . . This action is not an apologetic approach. It is intended to correct and eliminate any existing abuses and to furnish a means of ending much malicious rumor and gossip that have brought untold harm to our standing in the community. . . . It is expected that this effort will abort considerable malpractice litigation and will furnish protection against cranks. . . . The ethical physician has nothing to fear. . . . The relatively few of our profession who abuse privilege should soon fall into line. . . . Although no disciplinary action can be imposed by the Society on physicians who are not members, the publishing of the numbers of such physicians involved in complaints should serve to point up the ethical and professional standards required of our members '

"The public press has generally approved the publicizing of grievance committees. The Tulsa Tribune, in an editorial printed in May 1949, praised the Oklahoma State Medical Association for the creation of a grievance committee. In part, the editorial said: 'We applaud the public announcement of the names of members of the state-wide committee. . . . Often professional societies name grievance committees but keep the names secret, sometimes even from the members, and little good comes from the move even when it is sincere.'

"As this editorial points out, the public can make little use of a service if it does not know that the service exists.

"The information contained in the foregoing pages is ample evidence that the medical profession has followed through on the recommendations of the House of Delegates concerning the establishment of committees to hear complaints from the public. Forty-two constituent medical associations have developed machinery and methods for handling such grievances; four associations are in process of developing such programs; and two associations are leaving the handling of grievances to the component societies. . . .

"Actually, a review of available data indicates that the number of complaints is extremely small; furthermore, only a very small proportion of the number of complaints received represents justifiable grievances against physicians.

"Nevertheless, a committee is valuable even though few complaints are brought before it. It demonstrates the medical profession's willingness to discuss problems of medical care with the public. Its very existence is a deterrent to those members of the profession whose individual actions might do harm to the profession's reputation. It is an instrument for bettering the profession's relationship with the public and for demonstrating anew the physician's concern for the public welfare. When it has been made clear to individual physicians and to the public that the profession is no more in sympathy with those members who ignore their professional responsibilities than are those who are exploited, the activity of grievance committees will be reduced to a minimum. Their need remains, however, as a reminder to physicians 'to do unto others as you would have others do unto you.'"

ASSOCIATION HAS MANY NEW MEMBERS

The South Carolina Medical Association during the past year has acquired a large number of new members, most of them, of course, young men, just completing their training and internship. The addition of vigorous new growth is always a healthy sign, whether for a plant or for an organization. It speaks well for the Association, and likewise for the new members who affiliate themselves with it. It implies general satisfaction with the progress being made by the organization, recognition of its value, and willingness to cooperate in increasing its potentialities. Every report from a county society of the payment of dues of its members includes one or more new ones.

The general offices of the State Association in Florence are ready and anxious to extend any possible type of assistance to these new members in helping them to become familiar with the Association and its activities, its obligations and responsibilities. A letter or card addressed to the office, 120 West Cheves St., Florence, S. C., will secure information concerning any of the activities in which a new member may be interested.

All the new members, particularly the younger ones, and especially now that medical services are about to be included in the contract, should investigate the benefit to themselves, individually, and to their patients of their participation in the South Carolina Medical Care Plan. This, the Blue Shield Plan, is the doctors' own organization, initially capitalized by the State Medical Association and operated by the physicians on a nonprofit basis to encourage the enrollment of as many people as possible for voluntary insurance. *Every satisfied individual covered by voluntary hospital and health insurance is one less advocate for compulsory health insurance.*

THE ESSAY CONTEST

Response to the invitation to students in the schools of South Carolina to participate in the Essay Contest sponsored by the State Medical Association was very good. The contest was conducted on a National scale by the Association of American Physicians and Surgeons, the subject being, "Why the Private Practice of Medicine Furnishes This Country With the Finest Medical Care."

This organization has conducted such contests for six or seven years but this is the first time that the South Carolina Medical Association has participated. Two years ago, the State Association organized and conducted a contest on its own and, rather surprisingly, the response at that time appears to have been considerably better than this year. Probably the explanation is in the fact that most students considered their chances of winning in a National contest too small to warrant the time and effort involved in participating.

On the other hand, this would seem to have been offset by the fact that although the three best essays by pupils in the State were submitted for judging in the National contest, their writers will be awarded prizes by the State Association. In addition, several of the county societies offered prizes locally to the best two or three essays by pupils in the schools of the respective counties.

Another, and perhaps the real explanation for the fewer number of essays received at the office of the

State Association, is in the fact that some, at least, of the counties which offered prizes locally, sent in to the State office only the three essays adjudged best in their counties. We are therefore, without accurate information as to the total number of essays submitted by pupils throughout the State. In view of this fact—that some of the counties submitted to the State office only the two or three essays adjudged best locally—it is probable that actually the total number of students participating was approximately as large as two years ago.

The number of essays received in the office of the State Association for judging in the State Contest, was 49. These are in the process of being judged and when this appears the three best will have been forwarded to the Chicago office of the Association of American Physicians and Surgeons, on or before March 31st. The writers of these three essays will be awarded prizes by the South Carolina Medical Association, of \$100, first, \$50, second, and \$25, third prize. The winner will be invited to go to Myrtle Beach as the guest of the Association, and receive the award at some appropriate time in the proceedings of the annual meeting.

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TEN POINT PROGRAM OF THE SOUTH CAROLINA MEDICAL ASSOCIATION

1. Cooperation

To promote closer cooperation and better understanding between all agencies, groups and individuals concerned with providing and improving medical care for the people of South Carolina.

2. Extension of Medical Care

To study constantly the need and availability of medical care in each county of the State and in the State at large.

To promote plans for providing or improving medical care where is a need, particularly in the rural areas.

3. Pre-Paid Hospital and Medical Care

To make voluntary pre-paid hospital and sickness insurance available to all the people of the State (through Blue Cross, Blue Shield, and commercial insurance policies), and to promote the widespread purchase of such insurance.

4. Care of Indigent

To work with local county and state agencies, and with philanthropic organizations, toward securing good medical care for the indigent.

5. Public Health

To support the South Carolina State Board of Health in its broad program of preventing diseases and of safeguarding the health of our people.

6. Health Councils

To support the State Health Council in its announced program. To sponsor

the formation of a County Health Council in every county of the state, and to encourage our members to support and to work with these organizations.

7. Hospitals

To promote the expansion of present hospital facilities and the building of new hospitals—where there is a definite need.

To strive for highest standards of professional care in the hospitals in the State.

8. Medical Colleges

To support the Medical College of the State of South Carolina and to bend our efforts toward keeping its standards of education on a par with other medical colleges throughout the country.

To promote good nursing education and good nursing care throughout the State.

9. Education of the Public

To acquaint the citizens of the State with regard to the problems of medical care in existence today, to inform them as to what is being done to solve these problems, and to advise with them as to further plans for securing better health and better medical care for the people of South Carolina.

10. Political Medicine

To prevent political control or domination of medical practice or of medical education.

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Paroxysmal Tachycardia in Infants and Children

SAMUEL E. ELMORE, JR., M. D.

GEORGE D. JOHNSON, M. D.

FRED F. ADAMS, JR., M. D.

Paroxysmal tachycardia was once considered to be rather rare; but Hubbard¹ in 1941 reported 9 cases under 8 months of age and reviewed 19 cases under 1 year of age. Since then a number of cases have been reported. In the past 3 years we have treated 15 cases of paroxysmal tachycardia in infants.

The pulse of the normal infant varies from 110 to 140, and with febrile illnesses or crying may go up to 170 or slightly more. It is therefore easy to understand why this condition may so frequently be overlooked unless specifically watched for.

In a typical attack the infant seems at first fretful and may vomit shortly thereafter. The respiration becomes rapid and usually diaphragmatic in character. After a few hours the complexion becomes almost ashen gray; the infant is very restless, irritable, and frequently vomits. The infant becomes febrile with fever as high as 103° (F) to 104° (F) without any cause other than tachycardia apparent. The pulse is 180 or higher, entirely regular, and not varying with respiration, ocular pressure or such like procedures. The procedures which may halt paroxysmal tachycardia are only rarely successful in terminating the attack in infants. In our cases the pulse was above 200 when seen initially, in all but one case, and too rapid to count accurately. It is easy to see from this description of symptoms how commonly pneumonia may be diagnosed. If the condition persists the liver becomes enlarged, rales are heard at both bases, and chest x-ray reveals the lung fields congested and heart enlarged. Unless the attack terminates spontaneously or by specific therapy the infant will die of cardiac failure, usually after several days. This condition may or may not be associated with other illnesses. 11 cases of the 15 reported responded well and appear entirely normal.

The treatment which has given the best results as reported by others and used by us has been either digitalis or one of its extracts. The product we found most simple to use was "digitaline nativele"^o a solution of digitoxin. This was given as oral drops and in some cases vomiting seemed to interfere with its effectiveness. The dosage used by us has been rather

empirical; the initial dose being 0.02 mgm per kilogram of body weight. This was followed in 12-16 hours by either the same dose or a smaller dose depending on the initial response. If after another 12-24 hours the heart rate continued at its rapid pace 1/6 of the original dosage of digitalis was given.

REVIEW OF CASES

Case 1.

C. V.—White male age 4 months, admitted to hospital 10-28-48 and discharged 11-1-48. Patient was full term, normal delivery, birth weight 9¾ pounds. Mother 26, living and well; father 25, living and well. No siblings, no familial diseases. On evaporated milk formula with vitamin supplement.

3 weeks prior to admission he developed an upper respiratory infection which persisted. 4 days prior to admission his appetite fell off and 24 hours prior to admission parents first noticed very rapid grunting respiration and extreme fretfulness. 12 hours prior to admission he developed a fever and vomited twice. At time of admission the patient weighed 15 pounds 11 ounces.

Physical Examination: On admission examination revealed a fretful infant with an ashen gray color and rapid but not difficult respiration. The heart rate was too rapid to count accurately. No murmur was noted and sounds were of good quality. There was tenderness over the liver, the edge of which extended to within 1 finger breadth of the right iliac crest.

Laboratory: White blood cells 15,700, hemoglobin 53%, segmented forms 85, lymphs 15. Urine showed a trace of albumen. Temperature 98.6° (F).

The patient was placed in oxygen and given phenobarbital for sedation. 0.14 mg. of digitoxin was given. The next morning the pulse was 180 but the respiration was still very rapid and the temperature had gone to 100° (F). Another 0.14 mg. of digitoxin was given. The third day 0.02 mg. was given and the pulse came down to 130. The infant was discharged in good condition. Weight at discharge was 15 pounds and 2 ounces.

^oVarick Pharmacal Co.

Case 2.

B. J. T.—White male 8 months old admitted 1-19-49 and discharged 1-23-49. Normal delivery, birth weight 8 pounds, normal at birth. On evaporated milk formula. Mother 22, living and well; father 24, living and well. 1 sibling 2 years of age with pertussis. 1 maternal aunt had epilepsy and a maternal aunt had cancer.

4 weeks prior to admission the patient developed whooping cough for which he received hyperimmune human serum 2 days prior to admission. 1 day prior to admission he was given sulfa and penicillin because of severe vomiting and diarrhea. Because of extreme restlessness and fever he was brought to the hospital; vomiting still persisted.

Physical Examination; Weight of child 15 pounds. An acutely ill cyanotic child with temperature of 105.2° (F), rapid pulse, and audible respiration. Throat quite inflamed. There were scattered rales throughout both lungs. Heart rate too rapid to count. No murmurs were heard.

Laboratory: White blood cells 17,600, segmented forms 46, lymphs 52, monos 2, hemoglobin 80%. Urine showed 1 plus albumen.

Patient was placed in oxygen and given amytal for restlessness. 0.14 mg. digitoxin was given. Patient was also given 300,000 units of procain penicillin. Approximately 5 hours later temperature was down to 101.6° (F) and child was sleeping. Pulse remained above 200 per min. and 12 hours after first dose of digitoxin a second, equal to the first, was given. 24 hours after admission pulse was 120, respiration 35, temperature 100° (F). Oxygen was discontinued. Patient continued to improve. 0.02 mg. of digitoxin was given daily for the next 2 days when patient was discharged in good condition.

Case 3.

W. C. S.—White male age 2 years admitted 3-26-49 and discharged 3-28-49. Full term, normal birth. Birth weight 8 pounds. Breast fed with vitamin supplement. Immunized for diphtheria and tetanus and had had whooping cough at 1 year. Mother 29, living and well; father living and well; one sibling living and well.

2 months prior to admission child was given diphtheria antitoxin for severe sore throat. No culture had been done. In a few days the child had apparently completely recovered. 2 weeks prior to admission he had 1 injection of penicillin for laryngitis which improved. 4 days prior to admission the mother noticed that pulsations in neck were very rapid. Because this continued and the child tired easily he was brought to the office.

Physical Examination; Examination showed a white child in no apparent distress. Weight 22 pounds,

temperature 100° (F). Lungs clear to percussion and auscultation, heart sounds too rapid to count. Sounds were of fair quality and no murmur heard. The liver was 4 finger breadths below the right costal margin. Spleen was not felt.

Laboratory: White blood cells 16,000, segmented forms 48, lymphs 50, monos 2, hemoglobin 78%. Urine showed slight trace of albumen. Occasional white blood cells, 1-2 red blood cells, high powered field.

Patient was given 0.2 mg. digitoxin and this was repeated in 12 hours. The next morning the child was up playing and eating well. The pulse was slowing and the liver edge had receded 2 finger breadths. The next day the pulse was 90 and regular and the patient was discharged.

Case 4.

J. H. F.—White male age 5 months. Admitted to hospital 6-20-49 and expired 6-20-49. Full term, normal delivery, birth weight 5 pounds 11 ounces. On evaporated milk formula. No immunizations. No cod liver oil or orange juice. The child had always been "puny." 24 hours prior to admission he began to run fever, became very fretful, and vomited once. He cried all that night and the day of admission and had no appetite.

Physical Examination: Examination revealed a critically ill, small, undernourished infant, weighing 9 pounds 5 ounces; crying constantly with rapid respiration. Temperature was 105° (F) and the throat was red, the lungs clear, heart rate too rapid to count. No murmur noted. Remainder of examination normal except for cyanosis.

Laboratory: Blood culture positive for hemolytic staphylococcus. E K G showed right axis shift with sinus tachycardia. Pulse rate 200.

Child placed in oxygen. Digitoxin, 0.08 mg. was given. Penicillin 100,000 units given as was a cyclsis of 100 cc. lactate Ringer's solution. The temperature continued to climb and in 3½ hours had reached 106.4° (F). The breathing became labored, the skin cold to the touch. In the terminal stages ½ ampoule of coramine was given. The baby expired shortly thereafter.

Pertinent findings at autopsy were; heart which was enlarged 1½ times, the fibrous portions of the intraventricular septum was patent, and the foramen ovale widely patent.

This case does not represent the typical one of paroxysmal tachycardia due to the cardiac anomalies and septicemia. However, it is reasonable to assume that if treatment for both the infection and tachycardia had been started 12 to 24 hours earlier the outcome might have been satisfactory.

Case 5.

E. S. L.—Was a case seen in consultation. White female 2 months of age, admitted to hospital 12-7-49 and expired 12-8-49. Full term, normal deliver, on evaporated milk formula. Received vitamin supplement. No immunizations. Mother and father living and well. No siblings.

1 week prior to admission she developed a cold. Was taken to her local physician the day before admission and was given an injection of penicillin. The next morning she was much better but that afternoon she became very irritable, respiration became rapid, and later was cyanotic. The mother noticed that the heart was beating very fast the night before. Temperature was 98.6° (F) and weight 9 pounds 8 ounces.

Physical Examination: Examination showed a critically ill child, cyanotic, and with very rapid respiration. The heart rate was so rapid that it could not be counted and the sounds were of poor quality. Liver was not enlarged.

No laboratory work was done as the child expired before blood and urine could be collected.

Child was placed in oxygen, and penicillin, 100,000 units, every 3 hours was ordered. When called in consultation 1 hour after admission digitoxin 0.9 mg. was given by mouth. Baby failed to respond and 5 hours after admission expired. It is possible that had digitoxin been given intramuscularly or intravenously this child might have been saved. Unfortunately no autopsy was done.

Case 6.

M. T. B.—White male age 13 months. Admitted to hospital 6-3-50 and discharged 6-8-50. The child was full term but the labor was prolonged. Birth weight 6 pounds 8 ounces. Cyanotic at birth but a short while after was apparently all right. On powdered milk formula and received vitamin supplement. Immunized to diphtheria, pertussis, and tetanus. No previous illnesses. The infant had developed normally. Mother 22, living and well; father 24, living and well.

1 week prior to admission suddenly started breathing faster and faster and was taken to his local physician who started chloromycetin. Later the infant developed fever, breathing became very rapid and because of this he was sent to the hospital.

Physical examination revealed a restless, dyspneic and pale 13 months old infant. The weight was 12 pounds 13 ounces and the temperature was 101° (F). The throat was red and there was a post nasal drip present. There were scattered wheezes and crepitant rales in both lungs. Heart rate was extremely rapid with sounds of poor quality. The liver was 3 finger breadths below the costal margin. X-ray of chest revealed probable cardiac enlargement although heart shadow was not clearly delineated and a haze over both lungs suggested pulmonary edema.

Laboratory: White blood cells 13,000, segmented forms 72, lymphs 28, hemoglobin 83%.

On admission child was placed in oxygen. Procaine penicillin, 300,000 units, was started daily. 0.2 mg. digitoxin was given orally. Approximately 7 hours after admission the pulse was 153 and the respiration was less rapid and the child was resting. At this time 0.1 mg. digitoxin was given. The next day the child was out of oxygen and the chest was clearing. The pulse was 112. Because of the lung condition the child remained in the hospital 2 days more and was then discharged in good condition.

Case 7.

J. A. L.—White female 4 months of age admitted to hospital 7-22-50 and discharged 7-28-50. Full term, normal delivery, birth weight 6 pounds 4 ounces, normal at birth. On evaporated milk formula with vitamin supplement.

1 month prior to admission she had a crying spell that lasted 6 to 8 hours. 3 days prior to admission she became fretful and was seen by 2 physicians. On 2 preceding days the first of these physicians gave her penicillin and the second gave her penicillin and sulfa. She got no better and 1 day prior to admission began to turn blue at intervals.

Physical examination revealed an acutely ill, cyanotic child with temperature 99.4° (F), respiration 90, pulse 160, lungs clear to percussion and auscultation, heart sounds of poor quality, and weight 13 pounds. Liver 2 finger breadths below costal margin.

Laboratory: White blood cells 10,400, segmented forms 57, lymphs 46, monos 2, hemoglobin 80%. Urine 1 plus albumen with 8-10 white blood cells, high powered field.

4 hours after admission the temperature was 100° (F) and the pulse was 192 and the condition was worse. 0.12 mg. digitoxin was given. The next morning pulse was 160 but respiration was still very rapid and liver edge still down. 0.08 mg. digitoxin was given at this time. X-ray showed an enlarged heart and infiltration of the lower lobe of the right lung. Penicillin was given. At this time the baby began to take his formula. Next day the pulse was 132 but the respiration was still rapid and sounds muffled, so 0.02 mg. digitoxin was given. Over the next 2 days the baby's condition gradually improved. She was discharged on 7-28-50. The liver edge had returned to the costal margin.

It is not likely that the small amount of bronchitis would account for all the signs and symptoms, especially the rapid respiration, cyanosis, and enlarged liver. The heart failure here was probably due to toxic myocarditis and not so much to the rapid rate, but by reducing the rate with digitoxin undoubtedly recovery was hastened.

Case 8.

C. R. L.—White male age 9 days, admitted to the hospital 2-26-51 and expired 2-26-51. Full term, normal delivery, birth weight 9 pounds. Normal at birth, breast fed.

2 days prior to admission he became restless and irritable. The next day he seemed all right. The night before admission the child became extremely irritable and the respirations became fast and labored. Developed fever and was taken to his local physician who gave him some medicine but the infant got worse and became cyanotic in the afternoon. Because of this he was referred to the hospital for care.

Physical Examination: On admission examination revealed a very cyanotic and restless infant with rapid, grunting respirations. Weight 9 pounds, temperature 99.8° (F). There were many crepitant rales scattered throughout both lungs but no areas of dullness or bronchial breath sounds. The heart rate was too rapid to count and sounds were of poor quality. No murmur heard. Liver was 4 finger breadths below right costal margin.

Laboratory: White blood cells 16,700, hemoglobin 14.5 grams, monos 2, segmented forms 50, lymphs 48. Urine showed 100% mgm. albumen.

300,000 units procain penicillin was given and 0.09 mg. of digitoxin, and the child was placed in oxygen. The next morning the temperature was 102.4° (F) and the heart rate was still too rapid to count. Digitoxin was repeated in the same dose. Condition remained critical as the pulse remained over 200 per min. 12 hours after second dose of digitoxin a third was given. The rate failed to slow down and 14 hours after third dose the baby expired.

Autopsy revealed a cor trilobulare biatrium, which explains failure to respond to digitoxin. It is rather remarkable that the infant lived as long as it did.

Case 9.

G. D. P.—White male age 6½ months admitted to the hospital 3-24-51 and discharged 3-26-51. Full term, normal delivery, birth weight 7 pounds 4½ ounces. On evaporated milk formula with vitamin supplement. Past history revealed a few colds but no serious illness prior to admission. Father had asthma, no other diseases.

2 days prior to admission the baby became very fretful and developed a fever. He vomited small amounts on 2 or 3 occasions. The only other symptom was rapid respiration.

Physical Examination: Weight 17 pounds, temperature 102° (F), rapid respiration, pulse 200 per minute, sounds were of good quality and no murmur was heard.

Laboratory: White blood cells 6,500, stabs 8, segmented forms 42, lymphs 51, monos 1, urine negative.

Digitoxin 0.16 mg. was given by mouth and oxygen started. Amytal was given for sedation. The child was quiet within an hour and began to eat. 18 hours after admission oxygen was discontinued. Pulse at that time was 120 and there was no dyspnea. Temperature was normal. The infant was observed another 24 hours and was discharged in good condition.

Case 10.

T. V. M.—White male age 9 months admitted to the hospital 3-31-51 and discharged 4-3-51. Full term, normal delivery, birth weight 7 pounds 11 ounces. The child was never sick before present illness. He was on evaporated milk formula for 6 months and then was placed on cow's milk and received vitamin supplement. Immunized to diphtheria, pertussis, tetanus, smallpox.

The night prior to admission the child became very fretful, after he had gone to bed, and developed a fever. He vomited once. Because of continued fever and fretfulness he was brought to the office.

Physical examination revealed a temperature of 102° (F), respiration 36, weight 21½ pounds, fretful white male with both ear drums red and bulging. The throat was red, heart rate was 200 per minute, sounds of good quality and no murmur noted.

Laboratory: White blood cells 18,200, segmented forms 43, lymphs 52, monos 2, and eosinophiles 3.

The child was started on penicillin, 50,000 units every three hours, amytal grains ½, and 0.2 mg. digitoxin by mouth. The next day the pulse was 160, respiration normal, temperature 100.2° (F), and the child was beginning to eat. The ears were still red and bulging. Over the next 2 days the pulse rate dropped and the ears and throat cleared.

Case 11.

P. S.—Admitted to hospital 4-15-51 and discharged 4-18-51. Age 2 months, full term, normal delivery, birth weight 8 pounds 5 ounces, normal at birth. On evaporated milk formula with vitamin supplement. Given 1 diphtheria-pertussis-tetanus injection. No previous illness. Mother and father living and well. 1 sibling living and well.

Patient was fine until day of admission when shortly before midday meal he became restless and irritable and began to run a fever. He continued to be restless and temperature continued to rise. Because of irritability and fever he was brought to the hospital.

Physical examination showed a very restless child with rapid respiration, weight 11 pounds 10 ounces, temperature 105° (F), respiration 36, heart rate was too rapid to count accurately and sounds were of poor quality. The liver was 2 finger breadths below right costal margin. Remainder of physical examination normal.

Laboratory: Hemoglobin 11 grams, white blood cells 12,200, stabs 10, segmented forms 70, lymphs 16, monos 4, urine negative.

The child was given aspirin and placed in a sheet pack. 300,000 units procain penicillin was given. 0.1 mg. digitoxin was given by mouth. $\frac{1}{2}$ grain sodium amytal was given, intramuscularly, for restlessness. The next morning the pulse was 176 and the infant was less irritable. The temperature was 101.8° (F). The dose of digitoxin was repeated. That evening the pulse was 144, the child was eating and sleeping well, and the temperature was 100.3° (F). The next morning the temperature was normal, pulse 114, liver edge was at the costal margin, and the baby was discharged.

Case 12.

J. Y. F.—White female age 5 months. Full term, normal delivery, no previous illness. No immunizations, cod liver oil, or orange juice. Father and mother both living and well. 2 siblings living and well. No hereditary or familial diseases.

1 week prior to admission the patient developed a cold. She ran a fever and ate and slept well. The night prior to admission the infant cried out suddenly and the parents then noticed that she was breathing rapidly and cried on each expiration. She coughed some and vomited once. Respiration continued rapid and she would not eat. She was taken to a local physician who gave her an injection of penicillin for pneumonia. The patient seemed no better so was brought to the hospital.

Physical examination revealed a very restless, acutely ill, and cyanotic infant with temperature of 101.2° (F), respiration 80, pulse over 200, weight 15 pounds 3 ounces, chest had scattered rales mostly expiratory. The liver was 3 finger breadths below costal margin as was the spleen.

Laboratory: Hemoglobin 8.5 grams, white blood cells 9,700, segmented forms 70, lymphs 26, monos 4. The urine was negative.

The child was placed on nasal oxygen and 0.14 mg. digitoxin was given. Procain penicillin, 300,000 units daily, was started. A clysis of 100 cc. Ringer's solution was given. X-ray of the chest was taken that afternoon and revealed an area of density posterior to heart shadow on left, believed to be due to atelectasis. There was also some density in mid portion of left lung due to pneumonia. The temperature rose to 105.6° (F) in 12 hours and the pulse remained over 200. Amytal, $\frac{1}{4}$ grain, was given at intervals for restlessness. After 12 hours the dose of digitoxin was repeated because the pulse rate continued over 200 per minute. The temperature remained at 102° to 104° (F) and the pulse was still recorded at 220 after 24 hours. An additional dose of digitoxin, 0.01 mg., was given. 12 hours later an additional dose of 0.02 mg. was given and after this the pulse rate dropped

to 130 but stayed there for only a couple of hours after which it jumped to above 200. The next morning another dose of 0.04 mg. digitoxin was given but in spite of this the infant's pulse remained rapid. The child became quite cyanotic in spite of oxygen and expired on the third hospital day.

This patient may well have had some cardiac anomaly because of failure to respond to digitoxin. Unfortunately an autopsy was not obtained.

Case 13.

D. F.—White female age 4½ months, admitted to hospital 8-24-51 and discharged 8-28-51. Patient was full term, normal delivery, birth weight 7 pounds 6 ounces. Mother 28, living and well; father 30, living and well. 1 sibling living and well. No familial diseases. Child on evaporated milk formula, receives vitamins, cereals, fruits, and vegetables.

On day prior to admission patient became very fretful and irritable. In a few hours she appeared to have some difficulty with respirations and shortly after this her hands and feet became cyanotic. Because the infant was rapidly getting worse she was brought to the hospital.

Physical Examination: Weight 13 pounds, temperature 99.2° (F). A very fretful child with rapid respiration (40 per minute). The pulse rate was too rapid to count. The remainder of the physical examination was essentially normal.

Laboratory: Hemoglobin 11 grams, white blood cells 13,400, juv. 1, stabs 7, segmented forms 67, lymphs 25. Urine showed innumerable pus cells with clumps.

On admission the child was placed in an oxygen tent and given 0.12 mg. digitoxin. The child continued to be very restless although the pulse rate came down to 180. 8 hours after admission 0.06 mg. digitoxin was given. 9 hours after admission the pulse had dropped to 128 and the child went to sleep.

2 days after admission the temperature suddenly went to 103° (F) and the pulse rate to 180, and the child again became very fretful. Although the urine had cleared somewhat it was felt that the pyelonephritis was causing the fever; therefore she was placed on sulfadizine and penicillin. Within 12 hours the temperature was normal and the pulse was 148. The patient was discharged 2 days later in good condition.

Case 14.

R. H.—White male, age 7 months, admitted 9-14-51 and discharged 9-16-51.

Patient was a premature baby, normal delivery, birth weight 4 pounds 11 ounces. Mother 20, living and well; father 22, living and well. No siblings. No familial diseases. On powdered milk formula, gets vitamins, cereals, fruits, and vegetables.

The baby was apparently in good health until 2 days prior to admission when he became fretful and refused to eat. On the day of admission he developed a fever, vomited twice, and became extremely fretful and restless.

Physical Examination: On admission examination revealed a restless and fretful infant. Weight 17 pounds 7 ounces, temperature 102.8° (F), pulse rate over 200, and respiration 35. The only positive finding was the rapid pulse and a slight injection of the throat.

Laboratory: White blood cells 9,500, stabs 8, segmented forms 32, hemoglobin 11 grams, lymphs 56, monos 4, urine negative.

The patient was given grains ½ amytal and 0.16 mg. digitoxin. In 2 hours the baby had gone to sleep. The next morning his pulse was 180 but the temperature was still 102.4° (F). He was taking some formula. 12 hours after the initial dose of digitoxin a second was given. That afternoon the temperature was normal, pulse was 160. The next day the pulse was 140 and the infant was eating and sleeping well. He was discharged in good condition.

Case 15.

B. P.—White female, age 7 months, admitted 2-9-52 and discharged 2-11-52.

Patient was full term, normal delivery, birth weight unknown. Child was breast fed, received no vitamin supplement. He was given some food from the table, a few weeks prior to admission. Mother 33, has asthma, father 39, living and well. 3 siblings living and well.

Three days prior to admission the patient developed a head cold. The night prior to admission she began to run a fever, became quite fretful, and was taken to her local physician who gave her some liquid medicine. The morning of admission she seemed better but that afternoon she became "lifeless." She was taken to another physician who said she had pneumonia and gave her an injection of penicillin. Because the penicillin failed to make the baby show improvement in an hour she was brought to the hospital.

Physical examination revealed a well developed and nourished white female who was restless. Weight 16 pounds 3½ ounces, temperature 104.4° (F) pulse rate over 200, and respiration 64. The right ear drum was red and the only other significant finding was the rapid heart rate.

Laboratory: White blood cells 12,750, eos 1, segmented forms 41, lymphs 45, monos 5, and hemoglobin 10.5 grams.

She was given 0.14 mg. digitoxin and aspirin. 5 hours after admission her pulse had dropped to 165, respiration to 40, and the temperature to 102° (F). She was sleeping. The next morning the temperature was 99.2° (F), pulse 160, and the respiration 32. That day and night she ate and slept well and was discharged the next morning in good condition.

DISCUSSION

It can be seen from the review of these cases that only 6 are within the so called "pure" group of supraventricular paroxysmal tachycardia; the other cases being associated with a variety of other morbid conditions, 2 of which were congenital heart defects proved by autopsy. However, from a study of the clinical course of those cases associated with other disorders it becomes apparent that the greatest improvement came with the slowing of the pulse rate. This is particularly evidenced by a study of case 10, which had bilateral otitis media in addition to the tachycardia. As soon as the pulse rate had dropped to 160 the baby began to eat and was much less fretful, although the drums were still red and bulging.

The treatment used in these cases was digitaline nativele by mouth. Nadors et al² have used quinidine, prostigmin, and mecholyl in addition to digitaline nativele. They came to the conclusion that digitaline nativele was the drug of choice.

The dosage of digitaline nativele as employed by us is 0.02 mg. per kilogram of body weight and repeated in 12 hours if the rate is 160 or above or if signs of congestive failure are still apparent. This dose seems to give excellent results in the majority of infants and it is easy to calculate. Each drop of the solution used by us (digitaline nativele) contains 0.02 mg. of digitoxin so once the weight in kilograms is determined it is merely necessary to give one drop per kilogram by mouth. Once digitalization has been achieved, a maintenance dose of 1/6 the original dose is used daily if there is any tendency for the pulse to remain rapid (140 or higher).

Oxygen is an important adjunct especially in the smaller infants who show marked signs of congestive failure. Barbiturates are also of value in controlling the restlessness.

1. Hubbard, J. P.—Paroxysmal tachycardia and its treatment in young infants. *Am. J. Dis. Children* 61:687, 1941.
2. Nadors, A. S.; Galschner, C. W.; Roth, A. T.; Blumenthal, S. L.—Paroxysmal Tachycardia in Infants and Children, *Pediatrics* 9:167, 1952.

Psychological Development from Conception to Adolescence

W. H. CHAPMAN, M. D.
Bishopville, S. C.

(We would recommend this article not only as suggested reading for the parents of our little patients but as required reading for all physicians who deal with children in their practice or who have sons or daughters of their own. Without use of the technical jargon which floods much of our literature on psychology, Dr. Chapman presents a modern psychological view of the child in an interesting and enlightening manner. Editor)

If parents are to enjoy their children and guide them to a happy maturity, they must understand what is normal psychological development and the conditions that foster it. The parent who is worried and nervous and feels inadequate cannot give to the child the guidance he needs.

Every child is an individual with needs peculiar only to himself. Each child beginning at birth, meets certain problems which cannot be avoided. He must learn to meet, not only the requirements of his own individuality, but he must learn to conform to certain social and cultural demands. How these demands are made upon him and the understanding of his readiness for such changes, will either foster and stimulate his development or will frighten, frustrate and hinder him. The manner in which the child solves his problems and the feelings he develops while solving them, is the process by which personality develops.

DEVELOPMENT OF THE NORMAL PERSONALITY

What is Personality? In one sense it is the sum total of everything that you are and hope to be. It includes your physical body, your instincts, your intelligence, your feelings and, your hopes and ambitions. In a narrower sense, it means the way you usually feel about things and the manner in which you try to solve your problems. In either case, your personality of today, is the result of your past experiences. Every situation you have ever been in, every emotion you have felt and everything you have seen or heard, has affected your personality. Thus it is obvious that the child should experience those situations and emotions which will contribute to his general happiness. Many situations and happenings of childhood are forgotten but the feelings associated with that situation are buried in the subconscious mind. The same feelings then become associated with similar situations in later life. Many adult feelings about certain things are explained in this way.

The human baby is particularly helpless and dependent. While he possesses all the brain cells he will ever have, the pathways between the cells are yet to be developed.

The environment influences these pathways and thereby the personality. If rage and hate are the instincts most frequently expressed in the early period, they may over-balance feelings of love and kindness. To better understand how this may be, we must understand something of the unconscious mind also. The mind may be compared to an iceberg—one sees this large mass of ice above the surface of the water. However, this is only one-tenth of the iceberg—nine-tenths are below the surface. So it is with the mind. By far the larger part is the unconscious mind. This is not simply a storehouse, where past events are stored and forgotten. There are powerful forces within this part of the mind, which exert energy and influence our actions. For purposes of discussion we will divide personality into three parts.

ID This part of the personality contains all the instincts and drives. It can be thought of as the reservoir of love, hate, fear, self-preservation, sexual desires, and the desires to work, et cetera. This is the animal part of the personality, and is present in every personality. These instincts are bi-polar. That is they are not directed entirely outward upon others but partly inward upon the self also. Thus, a person does not completely love or hate someone but he has some of these feelings at the same time. These instincts do not consider morals, codes, or persons. The sole aim of instincts is to release tension and thus secure pleasure.

EGO This is the part of the personality that adjusts the instincts to reality. It is the conscious control of behavior. It is the vision of the self in relation to others and the environment. At first, the baby feels that he and the mother are one person. Later he realizes that they are separate persons and that he must act to secure what he wishes. Thus a concept of self is developed.

SUPEREGO The superego is that which tells us whether we are doing right or wrong. This is the conscience. It is formed by the gradual absorption and adoption of the taboos and ideals of those we love and respect. When impulses arise from the ID, the superego informs the ego so that it may decide what type of action to allow. The conscience works automatically in every day affairs. This saves much energy that would be necessary if the ego had to consider each and every problem anew.

Of these parts, only the first is inherited.

At birth, the sense of touch is highly developed. Of all the body, the mouth is the most sensitive area,

the most richly supplied with sensory nerve endings. In addition to obtaining food, nursing is a highly pleasurable exercise. When nursing is adequate, it stimulates breathing and the circulation. The baby who sucks as much as he requires is usually satisfied and contented. The warm close contact with the mother's body is also a source of stimulation and pleasure to the infant. Mothers should know that sucking a finger or thumb is normal and does not affect the teeth. The practices frequently used to discourage this habit are harmful and increase the length of time it is practiced as well as increase feelings of helplessness and anxiety.

We must understand, too, the importance of not forcing the baby to use a part of his body over which he has not gained control. The connecting of this system of nerves is completed first in the head. In other words, he first controls the muscles of his face and head. The first intentional acts are smiling and cooing and looking. These acts are fun when he masters them and he should be allowed full measure of the pleasure derived from all his satisfactions in this early period. Bright objects should be placed where he can watch them. A little later this development reaches the hands and you know how hungrily the baby explores and enjoys this touch sense. He should learn about all sorts of objects, rough, smooth, warm and cold. He enjoys banging his toys and getting them back when he thinks they are gone. By such play he overcomes much of his anxiety. We should stop to think what the world is like to this helpless one, he can see only what comes within the range of his vision. When he can sit up, what a change in his world! The dependency of this period should be realized, too long absences or too abrupt changes in those caring for the baby should be avoided. If it is necessary for the mother to be away, someone else should be familiar and loved by the child before the change is made, if this is possible.

When the nursing desire is not satisfied, the child develops the feeling that he is slighted, not getting all he deserves. He may go through life with these feelings of never getting enough, of never being satisfied. No matter how much he is really loved in later life, to him it will not be enough. Too long indulgence, when he is ready for more independence, may foster the feeling that whatever he wants he will receive with no effort on his part. The establishing of other satisfactions lessen the pleasure associated with nursing as he grows older and help him to give up this. Most babies whose feeding has been pleasurable and satisfying may be weaned gradually after the chewing and biting period is established.

By two or so, the mouth is no longer the source of the greatest pleasure. He is beginning to get about under his own power and the pleasure in movement and self mastery is very great. He is now more aware of the pleasure associated with bowel and bladder functioning. He is curious also about many things

including his body of which urine and feces are to him a part. He examines them, may play with them and values them.

This slow process of development from head to foot has by now given him better control of the nerves and muscles related to elimination. To expect this control before he is capable is extremely frustrating to the child. Mothers usually think because the child can talk about what he has done he is capable of co-operation. This law of growth and development which says "development proceeds in an orderly manner from head to toe" is important to good guidance. Parents should use this tendency of the child to help him to train himself. If demands are not made too soon or too harshly, he will want to use the pot to please the mother and keep her love. Many neurotic character traits are caused by too early and too strict training. If too severe, all pleasure is bad. Also it may cause stinginess, stubbornness, overcleanliness, obsessional habits. If the mother feels a sense of shame or disgust over bowel movements, it may become associated in the child's mind with this area and cause serious disturbance in the adult sexual life. If this period is handled wisely, however, normal development follows.

Genital interest and pleasure is at its height between 2½ and 4½ years, lessening during the fifth. This is the period of great curiosity about many things, including where he came from, how babies are born, why he is different from sister, father and mother.

The child's attitudes toward sex depend largely upon how his parents understand and feel about the bodily sensations that are normal in different periods and the child's natural pleasure in them. With increasing age and awareness, the child will notice the differences between his body and his mother's. Parents need to answer his questions truthfully and simply and without feelings of shame or embarrassment. This may take some doing, for regardless of the degrees she holds, a parent brings to this situation much of the same feelings her parent gave her when she asked similar questions. The answers are forgotten but the attitude remains. If a good relationship is maintained the child will probably ask the same question over again at another age. It is good to ask sometimes "what do you think?", for most children mix up fact and fantasy until they have many little ideas and theories of their own. Attitudes towards sex are built from many things besides the answers given to his questions. Such things as adult comment regarding pregnancy, calling a boy a sissy or a girl a tomboy, jokes and stories that belittle marriage, all play their part in building the child's attitudes toward sex.

The birth of a new baby can be a wonderful teaching opportunity. It is especially important that the small child's security in the family be maintained throughout this event. Merely telling him that there

is to be a new baby and that he must love and help care for it is not enough. How would you feel if your husband came home and said, "I'm going to have a new wife soon and I want you to help care for her and make her happy!" It will require good management and consideration of the older child. Reliving his own babyhood helps him to understand better than words what to expect. Seeing his own pictures as a baby prevents the disappointment many children feel when a playmate does not materialize. He need not be at home when the new baby arrives, with all the necessary attention to the baby and none to him. If father spends more time with him while mother is away and brings him a much desired toy the day the new baby comes home it helps. One mother kept inexpensive toys wrapped and handy so that when presents came for the new baby, there was something for the older child, also.

If the answers he receives are satisfactory to him, his interest turns away from his body and is directed to playmates and the outside world. In this period also it is normal for the little boy to be fonder of the mother, and jealous of the father, and for little girls to show greater love for the father and be jealous of the mother. This may sometimes be on an unconscious level but occurs normally in all children. Parents should be careful to avoid feelings of anger and resentment in this particular situation. They should not make the child feel guilty over his feelings but should help him to master them. This does not mean that parents should avoid all punishment during this period. When a little boy is jealous of a father and that father is *always* kind, never expressing any feelings of anger toward the boy, then the child can not express his own feelings of hostility and they are repressed.

The normal loving father is bound to feel annoyed and angry at a child at times. To punish objectively is good, but should be related to acts other than the sharing of the mother's love. The important thing is for parents to understand that the child does have these feelings, that they are normal and that they will pass as the child progresses to the next level of development. The same, of course, applies to the girl. Parents should not show their own jealousy or be overly affectionate during this period. This does not mean not be warmly loving, to kiss or cuddle the child. But the parent to whom this show of a child's affection is especially pleasing and who encourages it to the exclusion of a normal husband-wife relationship is fostering maladjustment in the child.

The wise parent in this period will maintain a good relationship with the child and foster feelings of security. To do so it is particularly important to understand the slowness of the child's growth, to avoid expecting more than he can live up to, to ask questions ourselves again, "What is he like at this stage?" Another important thing to understand are the fears which are common to this age. The little boy observing

the difference between his body and that of his sister is apt to think she was made as he was but has somehow lost her penis. He fears that if he does not please the all-powerful parents, this might happen to him. The little girl too thinks she has had a penis and it has been lost, either because of something she did or her parents did. Children need gentle understanding in these fears. With the little boy it is particularly important to avoid threats not only of castration but regarding harm to any part of the body. During this period the child needs an opportunity to learn his role in life from the parent of the same sex, to identify himself so to speak as a man or a woman. The little girls need to share in a warm understanding way all the little duties and later will go to making of herself a wife, a mother and a homemaker. The mother to whom housework is a burden and a bore and who thinks it is too much trouble to share house-cleaning and cooking need not expect her daughter to suddenly acquire these qualities at marriage. Likewise the boy needs a father who shares manly interests and acts with him, who stimulates his wish to grow up and to be a man and assume the role of father and husband.

All surgical operations should be avoided if possible in this period, when the child is experiencing fears within himself. The little girl should be told that she has something just as important—a baby sac which only little girls have. Some fears and dreams are normal and are to be regarded as a tensional outlet. When a child is overly fearful, the parents should examine their relationships for the cause.

It is important to understand that all young children, because of their helplessness, fear that their parents will go away and not return. If this should happen in this early period either through illness or death, the child, in addition to his real loss may have a feeling of guilt also, because of the angry feelings he has at times had for the parent. He should understand that he had nothing to do with the event.

Young children think in a wish fulfilling manner. Their imaginations are lively and their thinking a mixture of fact and fantasy.

The child's play is of vital importance. Play allows him to clarify his ideas and also helps parents in understanding him. He reproduces in his play many things that cause him anxiety; thereby he masters this feeling. He not only dramatizes past experiences but anticipates things which he fears might happen to him. One little boy played cops and robbers over and over to the exclusion of anything else. His mother was visited in an attempt to understand this need. It was found that some neighborhood boys who had been stealing were arrested in his presence. His mother had used this experience to threaten him about what might happen to him if he ever misbehaved.

Perhaps this would be a good point to discuss the question so often asked, "how can I influence the

spiritual development of my child?" Many parents are confused regarding the wisdom of early attendance at church and its value. Here again we can ask "What is the child like?" Babies are not born unselfish, kind and considerate. They are really primitive creatures with strong drives toward satisfying self alone. He gives up his selfish aims to keep the love of his parents, later his playmates. If he cannot feel secure and loved then we can see he has nothing to gain by giving up the pleasure of loving self—and may forever remain self-centered. This love of parents must be real and consistent, not an expression of their own selfish aims through their children. When the child lives in a home where there is an honest striving for something above and beyond their own welfare, he will also reach up and out. He may not as an adult believe and worship just as his parents do but he will believe in something and will have inner resources to take him toward his goal. The father is particularly important as a symbol of power. It would be difficult for a child who has a father who flies into a rage one minute over a childish act and then later laughs at the same act, to believe in a kind and all-wise heavenly father. There are studies which show that punishment may safely be very severe, as long as it is consistent and the parent really loves the child—not that we advocate strictness for we do not. But the point is made that there must be consistency; that the parents, themselves must have standards and beliefs, if the child is to have them. The question then of when to start going to church becomes an individual question. Even very small children understand without words what things are important to adults. If truth and honor and love of others are important in the home they will become important to the children, also, but in this as in other things the child will need to take increasing responsibility, and to have an opportunity to test himself in sharing and in facing reality regarding life and death.

After six, if the psychological development has been normal the child turns his interest away from self to the outside world. An interest in cleanliness, takes the place of his former pleasure in dirt, modesty replaces exhibitionism and sympathy replaces aggressiveness. He wants to be liked and assumes much of the responsibility for his own conduct, making his own decisions about what is right and wrong. This is a time of great learning; the child desires to learn and has energy to devote to it, for the energy formerly related to himself is now freed for other things. Some routine duties should be a part of every child's experience. The gangs and clubs of this age are the child's way of proving that he can get along without

his parents' supervision. Learning is easier and more rapid if the teacher is someone whom he can respect and with whom he can identify himself.

Allowing him to become gradually independent is perhaps the most helpful thing parents can do in this period and the most difficult for many. If parents can realize that underneath, he loves them just as much but that growing up and becoming independent of childish ways is hard for him, too.

In this as in many other things in life, he is ambivalent, that is, he both desires to be grown-up and also to remain dependent, cared for and safe. If parents add their own fears and doubts to his, the road is made more difficult. To be respected as a responsible individual, to be assured of love and security, not only when his disposition is good, but also when he is bad, is essential to growing up.

Parents should help the child in making friends by allowing him to entertain them at home, plan special trips when possible and provide a place to play without adult interference. He should make choices. This is a period when thoughts about sex are suppressed although some interest shows through the use of so-called dirty words. Boys prefer to play with boys and girls with girls.

Tensional outlets of this period are restlessness, ties, and compulsions. The child is now developing a much stricter conscience and some of these habits are normal. They are more apt to occur in a child whose parents are very strict, so if they persist, it is a good idea to look into the situation to see if too much pressure is being put upon him. If you understand how much upheaval for the child is involved in becoming independent, in developing self-control and a strict conscience, parents would apply less pressure themselves.

It is desirable for parents to think also, what does it mean to me to have this association with a child? No one can meet children in a democratic manner without some gain from their sincerity and honesty; by learning the value of little things; a respect for truth and the quest for true knowledge that comes through the eyes of a child. There is reassurance, too, for parents in a knowledge of the great margin of safety in life. The human organism will find a way to meet its needs in the most difficult of situations. We might paraphrase the poem, "I do not ask of any parent that he know all the answers, I only ask a great caring, an honest and humble caring, about what happens to children to their hopes and ambitions and that I ask of myself as of any other."

Current Status of Isonicotinic Acid Hydrazide in the Treatment of Tuberculosis

(In view of the widespread interest in the newer treatment of tuberculosis, we are glad to publish the following statement, prepared and released by the Executive Committee of the American Trudeau Society. Editor)

The Executive Committee of the American Trudeau Society has reviewed the available evidence on the antituberculous activity of isonicotinic acid hydrazide as presented by Hoffmann-La Roche, Inc., E. R. Squibb & Sons, and investigators cooperating with them. On the basis of this evidence, the Committee makes the following statement for the guidance of the medical profession:

1. *Chemical Structure*: Isonicotinic acid hydrazide^{*1} is a chemically pure, synthetically produced substance of the general formula $C_6H_7N_3O_2$.

It is obtained in almost colorless crystals which are highly soluble in water. A closely related derivative, which is also being studied for its antituberculous properties, is the isopropyl derivative.^{*2}

Isonicotinic acid hydrazide is also related to pyrazinamide^{*3} and to amithiozone.^{*4}

2. *Activity in Vitro*: Isonicotinic acid hydrazide is bacteriostatic *in vitro* against *M. tuberculosis* H37Rv in a concentration as low as 0.02 to 0.06 mcgm./ml. It apparently has a very narrow antibacterial spectrum, being ineffective *in vitro* against the common gram-negative and gram-positive pathogenic bacteria, against certain protozoa, and against the influenza virus in mice. It may possess some slight antifungal properties.

3. *Activity in Vivo*: In several species of experimental animals (mice, guinea pigs, rabbits, and monkeys), experiments on the effectiveness of isonicotinic acid hydrazide against tuberculous infection with virulent human strains of *M. tuberculosis* have given promising results in arresting the course of the experimentally produced disease. On the basis of these observations, isonicotinic acid hydrazide appears to be approximately the therapeutic equivalent of streptomycin, at least in the first few months of treatment. Observations on the emergence of strains of tubercle bacilli which may be resistant to isonicotinic acid hydrazide, either *in vitro* or *in vivo*, are meager, and it is not known if such strains will emerge during treatment or if such emergence will have therapeutic significance. A definite increase in resistance has been obtained *in vitro* with one strain (BCG).

4. *Toxicity and Pharmacology*: Although the toxicity of isonicotinic acid hydrazide has been determined fairly accurately in several species of animals, some aspects of the pharmacology and toxicology of the drug have not been completely elucidated. On the basis of available studies it appears that both iso-

nicotinic acid hydrazide and its isopropyl derivative are of relatively low toxicity in dosage ranges which appear to be effective. The drugs are apparently largely excreted in the urine. Within an hour or so after administration they appear to be well distributed throughout the body (blood serum, cerebrospinal fluid, pleural fluid).

5. *Dosage*: On the basis of preliminary studies, the indicated daily dosage is in the range of 3-5 mg./Kg. body weight (150-300 mg. per day for the average adult). This dosage is given by mouth in two or three divided doses. The drug may also be given parenterally.

6. *Toxicity in Man*: In the dosage range indicated, preliminary observations in man indicate that there is little significant or serious toxicity. The following have been observed but on a more or less transitory basis even though drug administration is continued:

- a. Constipation
- b. Difficulty in starting micturition (in males especially)
- c. Increased reflexes
- d. Positional hypotension and dizziness
- e. Eosinophilia (in about 10 per cent of cases)
- f. Slight drop (0.5-1.0 gm.) in hemoglobin concentration
- g. Occasional casts and traces of albumen and reducing substances in the urine

Toxic effects on the eighth cranial nerve, impairment of renal or hepatic functions, or dermatologic manifestations associated with the drug have not been observed so far.

7. *Activity in Man*: Preliminary observations on the effect of isonicotinic acid hydrazide on the course of tuberculosis in man have been limited largely to patients with far-advanced pulmonary disease, extensive tissue destruction, positive sputum and, as a rule, considerable symptomatology, many of whom have failed to respond or would not be expected to respond to other available therapy. In such patients, treated with 3-5 mg./Kg./day for up to five months of therapy (the majority treated for two to three months), the following changes in clinical course have been observed:

- a. Reduction in fever, if present, in two to three weeks, in the majority
- b. Reduction in cough, in the volume of sputum, and in the number of tubercle bacilli raised (as determined by smear). No information is available on conversion of the sputum as determined by culture

*Structural formula on attached sheet.

- c. Gains in appetite, weight, and strength
- d. Some clearing of the reversible component of the pulmonary tuberculous disease by X-ray observation
- e. Initial favorable response has been observed in such non-pulmonary lesions as draining sinuses and fistulae, mucous membrane tuberculosis, and in a very few cases of miliary and meningeal tuberculosis

8. *Problems:* At the present time complete information is lacking on many aspects of the therapy of tuberculosis with isonicotinic acid hydrazide. Among the unknowns are the following:

- a. The mechanism of action of the drug on the tubercle bacillus—whether it is tuberculocidal or tuberculostatic; the effect upon the enzyme chemistry of the tubercle bacillus, etc.
- b. The mechanism of action upon the host—basically, the precise toxicity in man
- c. The optimal dosage—the number of milligrams per day; whether it needs to be given every day; the optimal mode of administration
- d. The duration of therapy—whether its effect is comparable to that of streptomycin and para-aminosalicylic acid (PAS), indicating relatively long courses of treatment, or whether shorter courses may be as effective
- e. The rate of emergence of drug-resistant strains of tubercle bacilli
- f. The effect of the drug upon the bacteriology of the patient—data are lacking on conversion of sputum by culture; the tissue bacteriology after varying amounts of treatment will need to be studied
- g. The question of potential relapse after initial improvement
- h. The question of whether basic systemic therapy of tuberculosis (especially bed rest) can be modified as a result of treatment with isonicotinic acid hydrazide

9. *Precautions:* At present there is no reason to believe that the fundamentals of therapy of tuberculosis should be altered in any way when isonicotinic acid hydrazide is employed. Patients receiving the drug should be hospitalized for careful observation. They should be studied in institutions where potential toxic manifestations may be watched for most carefully and where effects upon the course of the underlying tuberculosis may be carefully observed so that suitable alterations of therapy may be initiated when indicated.

Routine laboratory precautions should include frequent blood counts and urinalyses, neurologic examinations, and tests for renal and hepatic insufficiency.

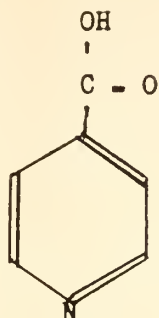
10. *In General:* The introduction of a new drug in the therapy of tuberculosis is likely to raise more questions for a few years than it will answer. There is no knowledge at the present time that isonicotinic acid hydrazide or its isopropyl derivative will accomplish more than has been accomplished with streptomycin and PAS. It may prove to be an additional drug of great value. It may be years before its exact contribution to the therapy of tuberculosis can be assessed accurately. A large reservoir of undetected and untreated cases of active tuberculosis exists throughout the United States, and there is every expectation that, in spite of the more effective chemotherapy of tuberculosis currently available, the need for hospitalization in institutions with qualified personnel and adequate laboratory facilities will increase rather than decrease. There is at present no basis for expecting that isonicotinic acid hydrazide, or any other drug available, can safely be counted upon to reduce the duration of hospitalization. Rather, in most instances, at least, it may lead to prolongation of hospital treatment since effective chemotherapy may facilitate desirable forms of therapy not otherwise possible.

It should be emphasized strongly that, with more numerous effective anti-tuberculous compounds available in the treatment of tuberculosis, more intensive case finding than ever will be indicated. Only through this means can maximum advantage be taken of improvements in therapy.

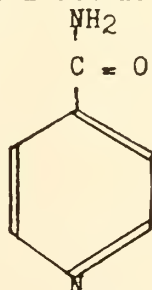
11. *Summary:* After a review of available data on the action of isonicotinic acid hydrazide and its isopropyl derivative upon the tubercle bacillus *in vitro*, and upon the course of experimental tuberculosis in animals and clinical tuberculosis in man, it may be stated that their demonstrated action, although highly encouraging, appears in no way to alter the basic principles of the treatment of tuberculosis as presently understood. Much more work will need to be done to ascertain the exact place of these drugs in the treatment of the disease. With several carefully coordinated studies in prospect, it is anticipated that further information will accumulate rapidly.

March 5, 1952

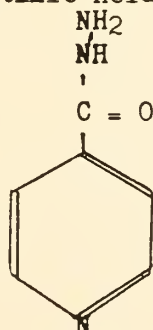
- 1—"Nvdrazid," trade name of E. R. Squibb & Sons; "Rimifon," trade name of Hoffmann-La Roche, Inc.
- 2—"Marsilid," trade name of Hoffmann-La Roche, Inc.
- 3—"Aldinamide," trade name of Lederle Laboratories.
- 4—"Tibione," trade name of Schenley Laboratories.



Isonicotinic Acid

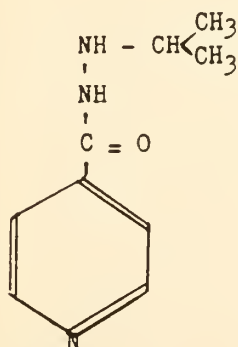


Isonicotinic Acid Amide



Isonicotinic Acid Hydrazide

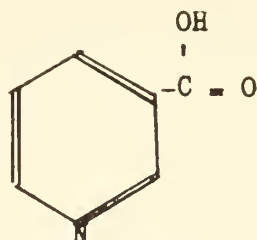
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Hoffmann-La Roche, Inc., "Rimifon"

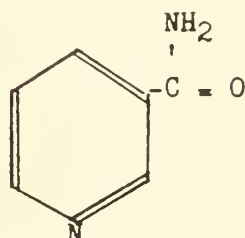
1- Isonicotinyl-2- Isopropylhydrazine

Trade name of

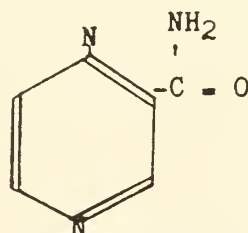
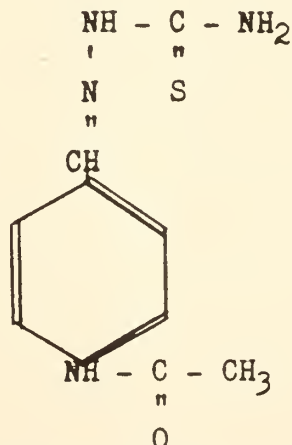
Hoffmann-La Roche, Inc., "Marsilid"



Nicotinic Acid



Nicotinic Acid Amide

Pyrazinamide, Trade name of
Lederle Laboratories, "Aldinamide"Amithiozone, Trade name of
Schenley Laboratories, "Tibione"

An Evaluation of Blue Cross and Blue Shield for the Hospitals*

ANTHONY J. J. ROURKE, M. D.
President, American Hospital Association
San Francisco

It is my hope in this paper to sketch a picture of the effects of prepayment hospital and medical plans on hospitals, as I see it today. A number of studies will give you a much better statistical analysis of what has happened over the past ten years, and therefore I am not going to load this paper with such data. To set the stage, however, I would like to point out that in 1940 about 12,000,000 people carried some form of prepayment hospital insurance, and by 1952 this has reached a level of about 80,000,000 people. In 1940 about 5,000,000 people carried some form of surgical protection, while in 1952 this figure has reached approximately 60,000,000.

It is interesting to note that each year the number of people enrolled in prepayment hospital or medical plans has increased. With 80,000,000 people carrying hospital coverage and over 60,000,000 people carrying some form of surgical coverage, the answer to the question, "Has this affected the hospital of today?" must be answered in the affirmative, and it now my task to try and outline how this phenomenal growth of voluntary prepayment coverage has affected the modern hospital.

For years hospitals have been concentrating on a *Public relations* program which includes the celebration of Hospital Day on May 12th, good press relations and favorable radio programs. Literally tons of leaflets have been passed out in an attempt to describe the workings of the hospital around the clock and behind the scenes. All these efforts have met with limited success because there still remained the problem of financing the hospital bill.

The BLUE CROSS - BLUE SHIELD movement has furnished the missing link in public relations between the hospital and its patients. We have known for a long time that our clients constitute reluctant visitors to our institutions and in every sense of the word are a "captive audience" during their hospitalization. They are in bed because of necessity rather than choice. They are all sick rather than enjoying good health. They are all facing a hospital bill which is an unwanted and unexpected expense. The little BLUE SHIELD or BLUE CROSS card does more than any other single item to combat this unhappy relationship between the hospital and the patient.

I feel quite confident that few Plan directors can ever appreciate the sheer joy which is expressed by the entering patient or his relative when he presents his admission card to the hospital admitting clerk.

(Presented at Annual Conference, Blue Cross and Blue Shield Plans, San Francisco, April 2, 1952).

Only people working in hospitals can fully appreciate the great sense of relief, not only for the patient but for the hospital, when this little gilt edged bond of security is presented for recognition. I can assure you that no other card in the world has so much confidence and security packed into so few square inches. Such little BLUE CROSS and BLUE SHIELD membership cards constitute the greatest and most satisfactory public relations program which has ever existed in the hospital field. Without a doubt, among the 80,000,000 people carrying cards, a great majority of them would rather sacrifice the membership cards in their fraternal orders and exclusive clubs, than part with their little certificate of preferred stock which carries such an excellent dividend upon demand when the need arises.

Second to its great importance as a public relations program is the tremendous advantage to the hospital because of the vast improvement in credit and collections. Because of the non-profit status of the voluntary hospital systems of this country, working capital has always been at a minimum. The constant demands of meeting ever-increasing payrolls and purchasing institutional commodities have created a need for an improved cash position in hospitals. It is customary in many hospitals to request a cash deposit before the patient is admitted, and if the patient is hospitalized beyond the time when the deposit is exhausted, to carry a large balance in its accounts receivable. The advent of BLUE CROSS and BLUE SHIELD in its present extended enrollment allows for definite planning in the financing of hospital operation. There has been a reduction in bad debts and a marked reduction in the percentage of collection expense.

A third advantage to hospitals of the prepayment movement is the outstanding improvement in accounting systems. Prior to the beginning of the movement, hospital charges set by-guess-and-by-gosh were the vogue of the day. Now, with a large percentage of all hospital bills being paid by prepayment plans, and their desire to pay cost plus a small write-up, it has become imperative for hospitals to focus greater attention upon better accounting. Out of such better accounting have come many forward steps in the financial operations of our institutions.

Fourthly, with the assured payment of this very large percentage of hospital bills, the institutions of this country have been able to vastly improve the working conditions of their personnel. Prior to World War II and consequently prior to the great expansion

of BLUE CROSS and BLUE SHIELD, hospital personnel were paid at substandard levels. Traditionally it was considered by many hospitals that the privilege of caring for the ill was adequate compensation to make up for the difference between hospital wages and the higher wages paid by industry. Just as an illustration of what has happened over the past decade, the percentage of hospital payrolls to total operating expenses has increased from about forty to sixty-five percent. At the present time hospital wages more nearly approximate those paid to personnel in other endeavors. Without increased occupancy and assured finances resulting from the prepayment method, the above change would have been very difficult and greatly delayed.

The last major advantage I will mention is the fact that over 80,000,000 people have thought of hospital care at a time when they are not ill—that is, at the time they are enrolled. I am sure that any sales organization successful enough to bring the attention of 80,000,000 people to a particular product would consider itself outstandingly successful.

Many years ago people thought of the hospital as a place in which to die. Somewhat later they considered it as a place to wipe out a lifetime's savings and be saddled with debt. In other words, the hospital was thought of only as a source of sorrow and only at a time of illness. Today, thanks to the prepayment movement, people are thinking of the hospital while they are well and with the full knowledge that they are spreading the painful cost of illness—if and when it comes. What greater factor in health education could be taught than, "While in Health Prepare for Illness"?

The possession of prepayment coverage has resulted in the admission of a greater number of patients earlier in their disease than previously had been the case. I feel confident that Dr. Cline will comment upon this very great advantage to the patient and to the physician.

I am reluctant to describe results of the prepayment movement in the realm of advantages and disadvantages, but rather as I have above mentioned certain problems which have been settled, I would now like to discuss some problems which have been created. While it is an illwind that does not blow some good for someone, the converse is also true—it is a rare good wind which does not blow some ill. One of the most serious problems created by the prepayment movement has been its effect in markedly decreasing the clinical material on the teaching services throughout the country. It is my impression that university services are receiving fewer teaching patients, and that this has come about because the 80,000,000 people now covered with prepayment insurance find it possible to elect private services rather than teaching services. If this trend continues, our traditional teaching service will disappear and some

other way will have to be found for training the doctors of tomorrow. This marked reduction in the teaching service will have a very adverse effect upon the training of medical students, internes, residents, nurses, dietitians and all the other technicians in the hospital field. Medical schools are greatly concerned about this lack of clinical material. Lest this statement be misconstrued, it is made with the full knowledge that the medical care furnished in our teaching hospitals throughout the country has been of the highest grade, under the supervision of some of the finest medical teachers in the world.

Hospitals of the future will be greatly jeopardized in securing personnel to staff them unless some way is found whereby medical personnel can receive training. This subject deserves deep thought and one suggestion that comes to mind at the moment is the possibility of prepayment health plans and medical schools agreeing to some type of program whereby certain groups may purchase hospital care for a reduced fee, and that the prepayment plan be billed for some figure less than the charges for the usual contract. This would, of course, mean that the medical school would underwrite the difference between the prepayment plan and the cost of the service. As you well know, this would not differ greatly from the manner of financing such clinical material under the previous system. The reduced premium might constitute an incentive for certain groups to elect teaching services. This suggestion is made regarding that group of persons who normally would be eligible for admission to teaching hospitals were it not for the fact that collective bargaining has resulted in the family possessing a hospital prepayment plan. If the BLUE CROSS and BLUE SHIELD programs continue to favor a voluntary nonprofit method of financing hospital and medical care, they must develop a keener awareness of the needs of the voluntary nonprofit system of medical education and try to develop ways and means of providing patients for the teaching services. They will continue to receive the highest grade medical care possible.

The advent of this tremendous expansion of prepayment care has resulted, in my opinion, in some unnecessary hospital admissions, some unnecessary diagnostic work and in some cases, an unnecessary length of hospitalization. A factor, I am sure, in the above, is the patient's possession of a prepayment health policy which in some cases constitutes a strong urge to cash in on something he feels he deserves. The existence of some unnecessary hospitalization and unnecessary diagnostic work has created problems between medical staffs, their hospitals and prepayment plans. Statistics have revealed from city to city, and from state to state a varying pattern in medical and hospital care, which I am confident will be studied carefully by the practicing physicians of this country and every attempt will be made to remedy any abuses which have existed.

A third problem has been created because certain benefits become available to hospitalized patients when they are not available to ambulatory patients. It is impossible to say how much effect this has had in the need for hospital beds, especially in our larger cities, but I believe it is an appreciable factor. I am confident that prepayment plans will have to more rapidly help solve the problems of covering diagnostic procedures on an out-patient basis, and that hospitals and/or doctors will have to develop greatly expanded facilities for rapid diagnostic procedures for private patients, which will be available to any doctor whether he practices in a group or alone. If we are going to lower the cost of hospital care, strengthen our prepayment plans by improving their financial situation, decrease the need for expansion of hospital beds—especially in large cities where multiple hospitals exist, decrease the man hours lost in employment, and bring to the public the best in American medicine and hospitalization, we must establish diagnostic facilities where physicians may obtain rapid answers with a minimum expenditure of the patient's time. Such facilities must be associated with a food service and bedroom service, where the patient may rest between procedures. Such out-patient diagnostic services would not entail the heavy cost of nursing service around the clock, the heavy expense associated with meals in bed, the large volume of visitors, the expensive telephone service, the operation of elevators and a host of other expenses of which all hospital people are so well aware. The present system of diagnostic procedures carried on at a snail's pace in a busy hospital must sooner or later give way to more modern methods. While there may be a great reluctance on the part of many of my medical friends to consider belt-line production or streamlining any procedure associated with medicine, I personally feel that there are two parts to the accumulation of diagnostic information; the first part deals with purely administrative techniques in traffic management and to this part I am perfectly willing to apply the most modern methods of rapid transit. The second part applies to medical interpretation and is based upon the education, training, experience and judgment of a qualified physician. In this part of the diagnostic procedure modern methods of belt-line production have no place. Careful study will reveal, however, that in many diagnostic problems, under our present methods, for every hour of professional consideration by the physician, twenty-three hours may be wasted in a standby system in an expensive hospital bed. Where such rapid diagnostic facilities are placed and under whose administration they are operated is open for discussion but I firmly believe that hospitals and/or doctors must rapidly develop such facilities, and prepayment plans must add the stimulus by developing ways and means of writing coverage and furnishing finances.

There is an ever-increasing and constant demand for a more comprehensive coverage of hospital expense by our prepayment subscribers. It is evident that this public demand must be met if we are to

continue successfully to increase the number of people receiving protection. It is an interesting commentary that the establishment of benefits, where no benefits existed, has created a demand for greater benefits. It would appear that the public has liked what we have brought to them and want more of it.

The ability on the part of the patient under the prepayment medium to purchase higher priced hospital accommodations has greatly increased the need for more private and semi-private rooms and less ward accommodation.

The need for more and more doctor-hospital-prepayment plan cooperation should not be listed under problems but rather under challenges to those of us associated with the health field. Today's combined meeting of the Blue Shield and Blue Cross, plus the opening remarks by Dr. Schriver on Sunday afternoon, are tangible evidence that doctors, hospitals and Plans in most areas are working together to bring greater benefits to the public.

Perhaps another major problem brought to hospitals as a result of the prepayment movement is the method and amount paid by plans for care purchased. This has had a great deal of discussion at hospital meetings for the past ten years. Suffice it to say that it will take the wholehearted cooperation of hospitals and Plans to solve this knotty problem and there are only two principles which constantly must be kept before both groups: First, hospitals must receive costs in order to continue their operations; and secondly, costs must be kept at a minimum if our voluntary plans are going to be able to continue to expand their wonderful work.

It must be abundantly evident to the hospitals and prepayment plans of this country that the concept of the hospital as an agency to dispense charitable care to the needy in our communities should no longer exist, especially if any portion of that care is being financed by those patients who are paying their own bills. In my opinion local and state governmental agencies must assume the financial responsibility of the medically indigent care in our hospitals. I know of no better way of doing this than through BLUE CROSS and BLUE SHIELD programs. It will behoove hospitals and prepayment plans to continually bring this to the attention of local governmental agencies who cannot continue to avoid their just responsibility.

SUMMARY

My evaluation of BLUE SHIELD and BLUE CROSS PLANS would list the following problems which have been solved or greatly helped:

1. They have furnished the much needed and most effective public relations tool in history.
2. They have greatly enhanced the financial stability of our hospitals.

3. They have directly or indirectly focused our attention on cost because of improved accounting methods.

4. They have made it possible to vastly improve the remuneration and personnel policies for hospital workers.

5. They have contributed to the health education of 80,000,000 people by concentrating their attention on hospital cost — not during illness, but during health.

6. They have made earlier hospital admission possible.

The following problems have been created or have grown:

1. They have caused a serious decrease in hospital patients on teaching services and if the present trend continues may cause the disappearance of the traditional teaching service.

2. They have in some ways—and inadvertently—been the cause of abuse of hospitalization and diagnostic facilities.

3. They have shown us the urgent need for rapid diagnostic service for private patients on an ambulatory basis.

4. They have changed the architectural planning of our hospital structure because of the shift to more private rooms and fewer wards.

5. They have created some tensions between hospitals and medical staffs, but in turn have shown a pattern of cooperative work between doctors, hospitals and Plans which has no precedent.

6. They have created the problems bound to

occur with third party payments as to methods and amounts.

7. They have allowed us to define and separate the costs of caring for the medically indigent and have indirectly made it obvious to us that local governments must assume their just responsibility for financing such care.

In conclusion, while evaluating the phenomenal public service performed by Blue Cross and Blue Shield, one cannot help marvelling at its rapid yet orderly growth. I can think of no other voluntary movement which can equal the beneficial impact it has had on the people of America. In history it will take its place alongside the tremendous achievements of medicine — such as immunization, purification of water supplies, pasteurization of milk, etc.

This paper would not be complete without paying tribute to you fine people who have made it possible. Yours is an enviable record. Continue your fine efforts and remember that the product you have so ably made available to the American public is constantly changing. Medicine is pushing back the frontier of the unknown. Your subscribers are not receiving the medical and hospital care of 1940 but rather the brand of 1952 which embraces antibiotics, chemotherapy, cortisone, ACTH, surgery of the heart and lungs, corneal transplants, replacement transfusions and a host of other advances which have occurred since your movement was born.

You continue your fine job and we will work hard on ours, and then between us we will make available to the citizens of this country not only the highest grade care on earth but also a way to purchase it.

CANCER

Edited by JOHN C. HAWK, JR., M.D., Charleston, S. C.

THE EARLY DIAGNOSIS OF CANCER

JOHN C. HAWK, JR., M. D.

It has been generally recognized for years and has become a cardinal principle of cancer teaching that early diagnosis, followed promptly by adequate treatment, offers the best opportunity for cure of any malignant lesion. With this in mind, a review of some of the diagnostic methods currently in use has been undertaken. It is hoped that individual physicians may be stimulated to assess the extent to which they are making adequate use of the methods actually available to them.

PATIENT AND PHYSICIAN AWARENESS

In the achievement of early diagnosis of cancer there is as yet no substitute for intelligent awareness on the part of the patient of the symptoms and signs of potential malignant disease. The educational pro-

gram of the American Cancer Society has done much to make lay persons cognizant of the following so-called "Danger Signals" which may herald the presence of cancer:

1. Any sore that does not heal.
2. A lump or thickening in the breast or elsewhere.
3. Unusual bleeding or discharge.
4. Any change in a wart or mole.
5. Persistent indigestion or difficulty in swallowing.
6. Persistent hoarseness or cough.
7. Any change in normal bowel habits.

The lay education program has included the distribution of many brochures and pamphlets pertaining to cancer, the use of various exhibits about cancer, and the showing of the film "Self Examination of the Breast" to women's groups of all types.

From the Cancer Clinic and the Department of Surgery, the Medical College of South Carolina, Charleston 16, South Carolina.

Some criticism has been leveled at the American Cancer Society and other organizations engaged in public cancer education on the grounds that latent neuroses may be activated and so-called cancer-phobias produced by publicity about cancer. This effect, although certainly not to be ignored, has been exaggerated and overemphasized. It is indeed a small price to pay for the early diagnosis and adequate treatment of large numbers of cancer cases.

Alertness on the part of every practicing physician to the high incidence of cancer and to its pleomorphic manifestations must be accompanied by willingness on the part of the physician to utilize to the fullest extent his own diagnostic facilities and capabilities and, in addition, when these do not suffice, to refer the patient to another physician or to a clinic for further studies. The slogan "Every Doctor's Office a Detection Center" serves to emphasize that much can be accomplished in early detection of cancer by a complete history and physical examination plus the use of simple diagnostic tests which can be made available in any office. Unfortunately, examination of the oral cavity, vaginal examination and digital rectal examination are too often omitted or are performed in a perfunctory manner. Proctoscopy, although a simple procedure, is utilized far too infrequently. Too often treatment of a lesion, in such a location as the oral cavity, the cervix or the skin, is undertaken without previous biopsy of the lesion to establish a diagnosis; and such treatment often is not only unsuccessful but actually harmful to the patient. Until the procedures mentioned are utilized fully by all physicians, the slogan given above will fall short of realization.

It is perhaps needless to state that full utilization should be made, wherever applicable, of any of the other well-recognized diagnostic procedures commonly available in a general hospital, such as x-ray diagnostic studies, hematologic studies, gastric analysis, stool examination and various endoscopic procedures (esophagoscopy, bronchoscopy, gastroscopy, cystoscopy, etc.). Since the indications for these procedures are so well-known, no further discussion of them will be undertaken in this paper.

CANCER DETECTION CENTERS

Since the establishment of the first Cancer Detection Center 25 years ago,¹ many similar centers have been set up, chiefly in large cities or in connection with medical teaching institutions. Such centers have varied greatly in the type of persons accepted for examination, the extent of detection procedures employed, and the mode of handling of further diagnostic studies and treatment. Considerable controversy has been raised as to the effectiveness and value of these centers and many centers have been discontinued. In California, for instance, where four cancer detection clinics were set up as pilot centers, three were subsequently discontinued.² The chief

criticisms of the clinics have been: (1) the difficulty in restricting the clinics to asymptomatic patients; (2) the low percentage of detections, estimated as low as 1 in 1000 by some; (3) the high cost per detection; and (4) the large number of patients who do not receive diagnostic procedures recommended when they are referred back to their local physicians. Clifton and Rush,³ in a recent study of the New Haven Cancer Detection Center, conclude that when a detection center is conducted in association with full diagnostic facilities and a proper follow-up system, the large majority of silent cancers are diagnosed and the patients who have these silent cancers are greatly benefitted by the early diagnosis, as indicated by the low incidence of metastatic lesions in these patients. They admit that the percentage of silent cancers detected in a group of patients as a result of a single examination of each patient may not be high enough to justify the cost of operation of a detection center, but feel that other indirect benefits justify the continuation of detection centers in selected institutions. Indirect benefits cited include the use of detection centers for the evaluation of new methods of detection, the contribution made by the centers to the education of the medical and lay public concerning cancer detection, and, lastly, the benefits from early diagnosis of diseases other than cancer. New advances are constantly being made to increase the effectiveness of cancer detection centers, but it is probably fair to say that at the present time they still play a relatively minor role in the overall program of early diagnosis of cancer.

SERODIAGNOSTIC TESTS FOR CANCER

For many years it has been recognized that the development of a specific serodiagnostic test for malignant disease, comparable to the Wassermann reaction for syphilis, would revolutionize the present concepts of the early diagnosis of cancer. As early as 1936 sufficient literature had accumulated to warrant a review of the subject by Davidsohn,⁴ and several subsequent reviews have been published by others.^{5,6,7} In 1950 Dunn and Greenhouse,⁸ in a monograph entitled "Cancer Diagnostic Tests: Principles and Criteria for Development and Evaluation," indicated that a general diagnostic test to be useful for mass screening purposes should be positive in at least 90% of cases with early, localized cancer, and should not yield more than 5% false-positive tests. Despite attacks upon the problem from many different angles, no tests which fulfill these criteria have as yet been developed. The iodo-acetate test devised by Huggins and associates⁹ has received considerable attention; but in a recent report describing the use in 1,328 persons of both this test and the tryptophan-acid test of Seibert,¹⁰ Riegel and co-workers¹¹ conclude that neither test is of value, singly or combined, (1) to indicate the presence of malignancy, or (2) to indicate whether or not a malignant growth has been successfully removed. Hill et al¹² have recently

evaluated four cancer serodiagnostic tests, plasma-heat-coagulation, methylene blue reduction, Raffo neutral-red, and Munro protective-colloid, and conclude that the four tests together or singly are too inaccurate for mass detection or differential diagnosis of cancer.

Although some degree of optimism may justifiably be entertained for the future development of a useful serodiagnostic test for malignant disease, it must be concluded that such a test is not now available. It is therefore worthwhile to continue to devote major attention to methods for the detection of cancer involving specific organs or body systems.

EXFOLIATIVE CYTOLOGY

The use of cytologic methods for cancer diagnosis dates back to the middle of the 19th century,¹³ but the widespread practical application of exfoliative cytology became possible only with the development by Papanicolaou of the fixing and staining technique which bears his name. Papanicolaou and Traut¹⁴ reported in 1941 on "The Diagnostic Value of Vaginal Smears in Carcinoma of the Uterus" and it was in the field of uterine cancer that the method first became used extensively. However, this method has now become widely accepted in the detection of lung cancer cells in sputum and bronchial washings, and more recently has been applied to the diagnosis of cancer of the oropharynx, esophagus, breast, stomach, intestinal tract, and genito-urinary tract, and has been employed in studying cerebrospinal fluid, pleural effusions, ascitic fluid, and joint effusions.

It is considered worthwhile, because of the growing importance of cytologic diagnosis, to present here a brief summary of some of the new methods employed and the results obtained in various fields. Much of the information given here is taken from papers presented at the Second National Cancer Conference in Cincinnati, Ohio, March 3-5, 1952.

Uterus: In several large series of cases reported recently, analyses have been made of the accuracy of vaginal and/or cervical smears in the diagnosis of carcinoma of the cervix and of the endometrium. The technique of obtaining material for smears still varies from clinic to clinic, some relying on material aspirated from the posterior fornix, while others take smears or scrapings from the cervix itself, using various implements. Graham,¹⁹ reporting on the accuracy of the initial smears (a single smear made from the secretion aspirated from the posterior fornix) obtained on 18,302 women, states that an error of 10.4% (missed diagnoses) occurred in the 641 cases of carcinoma of the cervix found in this series. False-positive diagnoses, calculated on the basis of the number of positive cases, fell from 15.3% in the first four years of this series to 4.9% during the last five years. Of great importance was the finding of 60 cases of unsuspected cervical cancer, 49 of which were pre-invasive. Cuyler,²⁰ reporting on smears obtained from a series of

21,598 patients in whom 747 gynecologic cancers were found, states that the number of cases of squamous cell carcinoma missed in the initial smear was 8.7% of the number studied, while the error for cancer of the endometrium was 30.1% (22 missed out of 73 cases). In explaining the latter high incidence of error, he cites both the problems involved in obtaining adequate smear material in cases of endometrial carcinoma and the difficulties entailed in differentiating malignant cells from those occurring in benign hyperplasia. Aspiration of material directly from the uterine cavity may help to obtain more satisfactory material.

Sponge biopsy, as described by Gladstone,¹⁵ is another method which may be employed to obtain cytologic material from the vagina and cervix.

Lung: Cytologic study of sputum and/or bronchial washings has become a valuable aid in the diagnosis of suspected lung cancer. McDonald and Woolner,²¹ reporting their experience with 1000 cases in which the pulmonary cytology report was positive for carcinoma, state that this method will not make the diagnosis of more than 60-70% of bronchogenic carcinomas, and that about 1% false positives may be expected. Herbut³⁵ summarizes his data in over 500 cases of carcinoma of the lung as follows: (1) Positive cytologic diagnosis in 88% of cases, (2) positive bronchoscopic biopsies in 31% of cases, (3) positive cytologic diagnosis and completely negative bronchoscopic findings for tumor in 29% of cases. Benioff³⁶ reports that when on adequate number of sputum specimens (five) are examined, positive cytologic diagnoses can be obtained in approximately 90%. Although cytologic studies are becoming more and more helpful, a negative result cannot be accepted as ruling out lung cancer. Clagett,²² Maier²³ and others have emphasized that surgical exploration should not be delayed because of negative bronchoscopic or cytologic studies in patients suspected of having lung cancer on the basis of chest x-rays.

Stomach: The difficulties encountered in differentiating benign from malignant gastric lesions, on the basis of clinical data, x-ray studies and gastroscopy, have stimulated efforts to develop techniques for obtaining satisfactory preparations of exfoliated cells from the stomach. Simple aspiration of fasting gastric contents or lavage of the stomach with saline fails to give satisfactory cytologic material because of the rapid digestive action on exfoliated cells and the difficulties encountered in concentrating the washings. Recently, however, two promising methods have been developed. Rosenthal and Traut¹⁶ have utilized the mucolytic action of a papain-cysteine mixture to concentrate gastric washings containing freshly exfoliated cells. Rosenthal²⁴ reports employment of this method in 1500 subjects without any noteworthy hemorrhages or other untoward effects. The first 400 have been followed adequately and 42 carcinomas have been demonstrated in this group. Of these 42,

33 showed malignant cells in their lavage preparations. Six of the nine missed cases had subtotal obstruction with consequent contamination of the washings by food and debris. This source of error is now being eliminated by preliminary washing and overnight suction prior to obtaining the specimen. Three false positives were encountered in this group.

Panico, Papanicolaou and Cooper¹⁷ have devised an inflatable balloon covered with netting, attached to a gastric tube, to serve as an abrasive agent within the stomach to recover large numbers of cells from the gastric lining. The technique employed and the results of the first 100 cases have been portrayed by Papanicolaou and Cooper¹⁸ in a 16 mm. color film now available from the American Cancer Society for showing to selected professional audiences. Analysis of the first 200 cases studied²⁵ shows that of the 43 carcinomas present, 31 were detected cytologically, seven were classed as suspicious and five were missed. The missed cases include two antral lesions not reached by the balloon, one lesion covered by a necrotic membrane, one scirrhous carcinoma and one lymphosarcoma. There was one false-positive case and in addition seven non-cancer cases were listed as "suspicious" (Class III) cytologically. Both of these methods are now being evaluated at several institutions including the Medical College of South Carolina.

Intestinal Tract: Lemon,²⁶ reporting the results of cytologic studies of duodenal drainage in 140 patients, 55 of whom had cancer, concludes that neoplastic cells can be recovered in two-thirds of patients with cancers primary in the gallbladder, biliary tract and pancreas. Only two false positives were encountered. Cytologic evidence of neoplasm was obtained twice as frequently as roentgenologic evidence. He also reports the results of proctosigmoidoscopic smears in 110 patients. He feels that this method is not as reliable as biopsy for the evaluation of visible polypoid lesions, but that it can offer cytologic evidence of malignancy of lesions in the sigmoid colon above the level of the sigmoidoscope.

Breast: Jackson and Todd²⁷ report that they have been able to express secretions from the breasts of 43% of a series of 6,835 patients, 1942-1951, all of whom had complaints referable to their breasts, but 70% of whom had no demonstrable pathologic condition in their breasts. A total of 8,406 breast secretions were studied. These workers find the procedure useful in diagnosing intraductal papilloma, and report operating on 160 cases of this condition from 1940 to 1949, 63% of which were revealed by cytologic study. They consider this condition as often premalignant. In their experience carcinoma is diagnosed infrequently, possibly because secretion is often unobtainable due to early blockage of the duct system. Saphir²⁸ also reports that this procedure is valuable in diagnosing intracystic papillomas and other benign conditions, such as Schimmellbusch's disease.

Genito-Urinary Tract: After reviewing the literature and polling a group of eminent urologists as to their opinions, Boyer²⁹ concludes that the prostatic smear as a routine screening test for men in the cancer age group has proved disappointing but deserves further controlled study. He feels that "negative" reports on prostatic smears should have little influence on the handling of individual cases, "suspicious" reports should call for further smear studies and close clinical follow-up, and that "positive" reports, returned by a cytologist well-versed in the interpretation of prostatic smears, should be considered of sufficient significance that in uninfected cases, producing repeated positive smears, serious consideration should be given to radical surgery, even in the absence of other findings. The prostatic smear has attained its greatest value in giving corroborative evidence in clinically suspicious cases, thus helping to eliminate disastrous procrastination. Scapier³⁰ has attempted to evaluate the results of cytologic smears of urine sediment and prostatic secretion obtained by massage from all asymptomatic male patients 50 years of age or over, seen in the Strang Cancer Prevention Clinic, 1949 through 1951. Over 14,000 patients were examined and 40 cases found showing cells with malignant characteristics. One case of carcinoma-in-situ of the bladder and one case of adenocarcinoma of the prostate were detected by this method. Pathologic confirmation had not yet been obtained in the other cases showing abnormal cytology, so no conclusions could be drawn as to the value of this as a screening measure.

The lack of adequate numbers of qualified experts in exfoliative cytology now constitutes the chief obstacle to the general use of this important diagnostic method by practitioners everywhere. The study of cytologic smears is exacting and time consuming, and although certain laboratories have trained technicians for the "screening" of a large number of smears, there still remains a large volume of work for the expert cytologist himself. No "short-cuts" have yet been devised which do not endanger the accuracy and therefore the true value of the cytologic diagnosis. In some cities and states, cytologic laboratories have been set up under the auspices of the local or State Board of Health to process cytologic smears (chiefly vaginal or cervical) sent in by any physician. In South Carolina it has been recommended to the State Budget and Control Board by the Executive Committee, South Carolina Division, American Cancer Society, Inc., that funds be appropriated to set up such a laboratory, but as yet such funds have not been made available. Such a service should be available to indigent patients on a free basis, but, because of the high expense of processing Papanicolaou smears, an appropriate fee should be charged patients financially able to pay. It is hoped that such facilities will be made available in South Carolina in the near future.

MASS X-RAY SURVEYS

Mass chest x-ray screening programs have been aimed primarily at detecting pulmonary tuberculosis,

but, as pointed out by Anderson,³¹ such surveys present an excellent opportunity for cancer case finding. Guiss³² has recently given a progress report on the Los Angeles County mass chest x-ray survey, involving 1,867,201 subjects. A total of 64,745 persons were asked to return for confirmatory films, and 54,648 complied. Among the confirmatory films 3,500 were placed in the Chest Tumor Registry as constituting "Chest Tumor Suspects," an incidence rate of tumor suspects of 1.9 per 1,000 examined in the survey. The number of chest neoplasms eventually confirmed was 240, of which 177 were malignant tumors and 63 benign. There was, unfortunately, a considerable delay between the time of taking the 70 mm. film and the time of surgery in many cases. From the narrow viewpoint of control of lung cancer, each proven bronchogenic carcinoma represented an expenditure of \$9,625.00 on the part of the entire survey, but it must be recalled that the survey was designed primarily to detect tuberculosis, 18,785 cases of which were actually found. Mass x-ray surveys will undoubtedly continue to be increasingly valuable means of detecting early, asymptomatic lung cancer.

In several centers photofluorography has been employed as a screening examination for gastric lesions. Wigh and Swenson³³ have reviewed their results in a photofluorographic survey of 5,096 examinees, age 40 or over, with no significant gastro-intestinal complaints, and report that they found three gastric carcinomas, five gastric adenomas and three other stomach neoplasms, types not yet verified. They attach as much significance to uncovering gastric adenomas as silent gastric cancers and conclude that "gastric photofluorography is an inexpensive cancer test with single organ specificity, high accuracy and a low false-positive rate." Further experience by other groups will be necessary before it can be judged as to how wide an application this method deserves as a screening measure.

RADIOISOTOPES

Radioisotopes have received wide attention as both diagnostic and therapeutic tools in cancer work. From the standpoint of achieving early diagnosis of the existence of cancer they have been of little or no help. However, in localizing tumors known or suspected to exist they are sometimes useful. Radioactive iodine (I^{131}) has been employed chiefly in localizing metastases of thyroid carcinoma; even here its use is severely limited by the fact that only 10 to 20% of thyroid cancers will concentrate sufficient iodine to make accurate localization possible. More recently serum albumin tagged with I^{131} has been employed successfully for localizing some brain tumors. Radioactive phosphorus (P^{32}) has been used with variable success in the localization of brain tumors and in the diagnosis of intra-ocular tumors. More important, of course, are the uses for which isotopes are being employed in various phases of fundamental research in cancer.

TUBLELESS GASTRIC ANALYSIS

Segal et al³⁴ have reported a most ingenious method of detecting achlorhydria without the necessity of passing a gastric tube. They give by mouth a compound called Diagnex-QH which is hydrolyzed in the stomach if dilute hydrochloric acid is present, forming quinine hydrochloride which is absorbed in the intestine and rapidly excreted in the urine. By determining the amount of quinine hydrochloride in the urine they are able to estimate the presence or absence of free gastric hydrochloric acid. They detected 166 instances of achlorhydria in 940 patients tested by this means. They feel that this may develop into a suitable method of screening asymptomatic individuals for achlorhydria, which in turn may be used as a basis for instituting further tests for gastric cancer.

SUMMARY

- (1) The importance of early diagnosis and prompt treatment of cancer has been cited.
- (2) Emphasis has been placed on the importance of lay education in developing awareness of the potential danger signals of cancer.
- (3) The need for alertness on the part of every physician to the possible existence of cancer in any given case and for full use by the physician of all diagnostic methods at his command has been stressed.
- (4) The values and limitations of cancer detection centers have been reviewed.
- (5) The failure of any serodiagnostic test for cancer yet developed to meet the criteria for a useful test for screening purposes has been cited.
- (6) Some of the newer methods of cancer diagnosis have been reviewed.

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MAY, 1952

ANOTHER MILEPOST

As this is being written plans are being made for the 1952 annual meeting, and when these words appear in print a new year will have started in the Association's work. Another milepost in our history is being passed.

The past year has seen steady if not spectacular progress in our activities. Our president, Dr. J. D. Guess, has spared neither time nor energy in touring the state, discussing Association affairs with district and county societies. The Council has met on several occasions and the House of Delegates has had one called meeting — to consider matter of particular importance. The Medical Service Plan has seen steady growth, groundwork has been laid for the formation of a grievance committee, the special committee on infant care has started its work with an investigation of premature deaths, our Constitution and By-Laws have been brought up to date. And the usual and unusual activities of the Secretary and Executive Secretary and other officers have been handled with efficiency.

Ours is a democratic organization with every member of the Association having the right to cooperate with, to criticize, to protest against, or to ignore the work being done. The progress or lack of progress in our work in the days ahead will depend upon the will of the majority of our members.

E. MARVIN DIBBLE

Lives and not words are the best answer to those who say that the spirit of service no longer lives in the practicing physician of today. And nowhere could our association find a stronger argument in behalf of physicians than in the person of E. Marion Dibble, M. D. of Marion. As a family physician for over fifty years, as member and chairman of the State Board of Medical Examiners for two decades, as a church member and a citizen and a friend, he has served his own community and the state with honor and devotion.

Last year our Association presented Dr. Dibble with his "fifty year button," and we were honored in having Dr. John Cline, President-elect of the American Medical Association, make the presentation in our behalf. This year, on his 74th birthday, the city of Marion paid him tribute and we publish with pride the following editorial which appeared in the Marion Star—

"Wednesday morning at Marion Memorial Hospital, recognition was made of a man who has lived and served clean, gracefully, and faithfully the citizens of this community for the past fifty years. Dr. E. Marvin Dibble, more affectionately known as "Dr. D.," has, beyond a doubt, set an example that others might well follow. No citizen of Marion is more respected or beloved by the rank and file, and the ceremony yesterday morning was timely and fitting.

"His birthday was an opportune time for congratulations, and Marion Memorial was the proper place for the occasion, since he has contributed so much of his time and technical knowledge toward the realization of this long-cherished dream.

"To the many friends and patients who had a part in the project, this was only a small expression of their love and affection toward Dr. Dibble. No doubt many would like to have done, or said, more. But there is little doubt in our mind but that he grasped its full significance. Because at the ceremony he was too emotional to speak. But it was just as well. Because Dr. Dibble has long spoken his attitude toward the people of Marion and community."

SPIRITUS FRUMENTI

The story is told of a colored parson who was invited to preach a trial sermon in a church which was considering calling him as pastor. Sensing the importance of the occasion, he chose as his subject the Ten Commandments. As he dwelt upon the problems of blasphemy, adultery, observance of the Sabbath, murder, and parental piety, his audience was

wholly with him. But when he came to the question of stealing and mentioned specifically the case of stealing chickens, one of the congregation leaned to the man next to him and whispered, "Brother this new preacher won't do. He not only preaches but he butts in on our personal affairs."

Perhaps there are those who feel that this editorial is one which is meddling in personal affairs but we will risk the wrath of those who are so minded and present what we have to say.

We would like to make some passing comment on a phase of that well-recognized American pastime, throwing spiritus frumenti "down the hatch."

It is not of the habitual drinker of whom we wish to write but rather of that somewhat peculiar individual who, though a moderate drinker or tetotaler at home, suddenly tosses all inhibitions aside when he goes to a meeting or convention of his colleagues and makes it his business to absorb liquor to the point of saturation. And there are physicians—fortunately their number is not as great as is their reputation—who fall in with this group of individuals.

Attendance upon medical meetings, conferences, and conventions in this state and elsewhere have shown us the tendency on the part of some doctors to regard the occasions as ones in which to bury their worries, their woes, their tiredness—and their higher sensibilities — through the medium of the up-ended glass. That the meeting might be held for the scientific enlightenment of those present or for the discussion of matters important to the medical profession does not seem to be of any concern to them—they want their liquor and see to it that they get it. In the end they not only develop a severe headache themselves but become a real headache to those around them. Their loud talk and their boisterous conduct is an annoyance and nuisance to even their closest friends.

There are three possible ways of dealing with these individuals. First, medical meetings could be held without any "social hour." "Inconceivable," some will say. And yet it is done in some places. We attended a district meeting in Winnsboro in company with a colleague some time ago. Four papers were presented, dinner was served, and an invited guest addressed the audience during the course of the afternoon and evening. No drinks were offered or even mentioned. On the way home, my friend made this observation, "That was one of the pleasantest meetings I have ever attended. Everything eliked, all seemed interested in what was said, no one draped his arm over my shoulder and blew his breath in my face, and I will have a clear head in the morning."

A second method of meeting the problem is that of limiting each person to one or at the most two drinks. This is attained through the mere expedient of having only so many bottles of the fluid avail-

able. We have seen this done to good effect in some of our national meetings. But it seems that one of the functions of a good host (be it an individual or a medical society) is to keep the visitors satisfied and it becomes a discourtesy to allow the situation to develop where a man wants to freshen up his last drink and there is not the wherewithal with which to accommodate him. Further, the man who really wants his liquor can always bring it with him.

Finally, it might be possible to designate a special room for those who want to skip the scientific and business session and to leave these men to their own natural thirst, provided that they would stay within confines and not wander out to bother others. But this is still a free country and men may go where they please.

So we end our discussion: diagnosis—too much spiritus frumenti by a small but loud group at medical meetings; treatment—questionable and so far, unsatisfactory.

HOW THEY STAND

Every voter is interested in the stand which prospective candidates for President are taking on various subjects. Physicians, in particular, are concerned with the stand on the issue of socialized medicine. The following information has been sent to us from A. M. A. and we pass it on to our readers without comment:

Senator Robert A. Taft, (R), Ohio—One of medicine's staunchest friends in the United States Senate. He is campaigning vigorously against Socialized Medicine and all forms of State Socialism. He voted *against* Reorganization Plan #1 which, if not defeated, would have created a Cabinet position for Federal Security Administrator Oscar Ewing.

General Dwight D. Eisenhower, (R)—He has made no public statement as yet on the issue of Compulsory Health Insurance or Socialized Medicine. He has spoken out against some socialistic proposals, but his leading backers in the Presidential race include several so-called "Fair Deal Republicans" whose position on the medical issue is at least questionable. General Eisenhower's position may be clarified within the next few weeks. In this regard, yesterday Senator Dirksen (R), Illinois, eabled Senator Lodge (R), Massachusetts, who is at Eisenhower's headquarters, asking that he get Eisenhower to make a public statement on eight key National issues. On our issue, Senator Dirksen specifically asked: "Is he (Eisenhower) for or against Socialized Medicine?"

General Douglas A. MacArthur, (R)—Outspoken opponent of Socialized Medicine, Government controls and all socialistic proposals.

Harold E. Stassen, (R)—Mr. Stassen took a strong position against Socialized Medicine in a series of

articles written for The Reader's Digest in January and February of 1950, following a trip to England and a study of the British system.

Governor Earl Warren of California, (R)—A constant and determined advocate of Compulsory Health Insurance, even though he denies that this is Socialized Medicine. Governor Warren caused Compulsory Health Insurance legislation to be introduced at the 1945, 1947 and 1949 sessions of the California State legislature and fought vigorously, but unsuccessfully, for its enactment. He has become a bitter critic of the medical profession and, if elected President, undoubtedly would sponsor National Compulsory Health Insurance legislation similar to that advocated by the Truman Administration. He has also said in recent addresses that he favors virtually all of the New Deal legislation enacted during the past 20 years, but feels he could administer the program better than the Democrats.

Senator Estes Kefauver, (D), Tennessee—In a letter to Dr. R. B. Robins of Camden, Arkansas, a member of the AMA Coordinating Committee, dated January 30, 1952, Senator Kefauver said: "As you know I have heretofore taken my position against the medical bill that is now in Congress. I don't want anything to happen that may bring about Socialized Medicine." Senator Kefauver, however, voted for Reorganization Plan #1, which would have made Mr. Ewing a Cabinet member, and has supported some other aspects of the New Deal program.

Governor Adlai E. Stevenson, (D), Illinois—The current issue of Newsweek (April 14, 1952) carries an interview with Governor Stevenson, dealing with major National issues. He was asked the question: "Do you favor compulsory national health insurance?" His answer, according to Newsweek, was: "Basically, the problem is how to lift people over the costs of major illness. I don't know whether voluntary plans can do the job. I think the new commission on medical needs may well add some light and remove some heat, enabling us to find a satisfactory solution to this perplexing problem."

Senator Robert S. Kerr, (D), Oklahoma—He voted for Reorganization Plan #1, which would have given Oscar Ewing Cabinet status, and has generally favored New Deal socialistic legislation.

Senator Richard B. Russell, (D), Georgia—An outspoken opponent of most socialistic legislation; he voted against Reorganization Plan #1.

Senator Harry F. Byrd, (D), Virginia—A vigorous opponent of Socialized Medicine and all forms of Socialism. He addressed the Los Angeles Mid-Winter meeting of the AMA on this issue, December 5, 1951.

Vice President Alben Barkley, (D)—He has supported most of the Fair Deal program. To the best of our knowledge, he has not taken a public position on Socialized Medicine.

MINUTES OF HOUSE OF DELEGATES

December 9, 1951

The meeting was called to order at the Columbia Hotel at 3:10 p. m., by Dr. J. D. Guess, President of the South Carolina Medical Association.

The floor was first extended to Dr. O. B. Mayer, Chairman of Council, to state the object of the meeting. Dr. Mayer told in detail of the events leading up to the necessity for some action by Council. A meeting of Council was called to obtain information concerning the changes in the set-up of the State Board of Health, as announced in the public press, which was the first news of the changes that had come to the attention of Council. First, the Executive Committee of the State Board of Health was called to meet with Council and each member of the Committee was asked to express an opinion. Next in order, State Auditor J. M. Smith was interviewed, along with a member of his staff, who had conducted an investigation of the Board of Health under the direction of the State Budget Commission. An opinion was obtained from them also, concerning the changes. Dr. Guess and Dr. Mayer then conferred with the Governor regarding these changes. The Governor suggested that the Medical Association submit a plan for changes in the set-up of the Board of Health. Dr. Harry Mustard, an expert in public health matters (who happened to be in South Carolina on vacation at this time) kindly consented to make an investigation in the set-up of the Board of Health, at no expense to the Association, and to advise what changes he thought progressive. After a period, Dr. Mustard made a report to Council with careful explanations of suggested changes which he thought advisable. Council then appointed a Committee of five to make a study of Dr. Mustard's report and to report back to Council any suggestions. This was done and after many revisions, the report which was mailed to the members of the House of Delegates, was adopted. Dr. Wallace, Chairman of the Executive Committee of the State Board of Health, was invited to all the meetings and his opinion was asked on all points of the suggested recommendations which had been mailed to the members of the House of Delegates.

In order that the House of Delegates might have all the information which was available to Council in making these resolutions, Dr. Mayer called on: First, Dr. J. I. Waring to report on the Mustard Report; second, on Dr. Joe Cain to give the political background; third, on Mr. Meadors to explain the merit system in operation in the State Board of Health; fourth, on Dr. C. N. Wyatt to talk further about the Mustard Report; and fifth, on Dr. Guess, in the absence of Dr. Price, to bring out the highlights in the suggested changes submitted to the House of Delegates by Council.

The House of Delegates was then thrown into a "Committee of the Whole" in order to freely discuss

the related matters so that each delegate could express his opinion. Under these conditions the following were recognized as follows:

1. Dr. Wallace, who sang the praises of the Board of Health as to services, efficiency, and economical management.

2. Dr. Olin Chamberlain of Charleston was next recognized. He likewise praised the services of the members of the Executive Committee of the Board of Health. He objected to any criticism of the members of the Board of Health, and also, to the mentioning of Dr. Mustard's name in connection with the recommendations. In the recommendations by Council, Dr. Chamberlain objected first, to the nominations of three men for the Health Officer (the Governor to appoint one), and second, to having the Legislature fix the salary of the Health officer.

3. Dr. R. M. Hope of Charleston moved that the resolutions of the Charleston group, on the reorganization of the Board of Health, be read by Dr. Chamberlain at this time. This was seconded, voted on and carried. The alternate plan was then read to the "Committee of the Whole," by Dr. Chamberlain.

4. Dr. James A. Hayne was then recognized and he told of his experiences while holding the position of State Health Officer and he gave his advice.

5. Dr. K. M. Lynch was recognized; he confirmed and approved of the reports of Dr. Wallace and Dr. Hayne. He then moved that the "Committee of the Whole" adopt the plan, as suggested by Dr. Chamberlain, and recommend to the House of Delegates that it adopt the alternate plan instead of the plan suggested by Council. This was seconded.

6. Dr. Robert Wilson was then recognized. He objected to the change in these resolutions, whereby the State Medical Association was no longer the State Board of Health. He offered an amendment to that effect. This was seconded.

7. Dr. Clay Evatt was recognized; he objected to the term of office of the Executive Committee members being limited to four years.

8. Dr. Workman, seconded by Dr. W. T. Barron, offered an amendment to recommendation No. 6, whereby the words "and employ" be inserted after the words "to appoint" in line four of that recommendation.

9. Dr. William Weston, Jr., after being recognized, talked briefly.

10. Dr. W. A. Smith of Charleston was then recognized. He commended Council for suggesting changes in the set-up of the Board of Health.

There being no further inclination to discuss the matter, the question of the adoption of the substitute plan, offered by Dr. Chamberlain, with amendments, was brought before the Committee by Dr. Guess. Dr. Wallace gained the floor to offer the amendment that the new Board of Health meet within 30 days

after the adjournment of the Legislature in order to organize and be ready to function on July 1st, following.

Dr. Joe Cain then moved that all motions and amendments be tabled so that a discussion of the two suggested plans could be conducted. The motion to table was lost.

Dr. E. M. Dibble of Marion thought the presiding officer was mixed up but the chair did not agree.

Dr. R. M. Hope gained the floor for further discussion of the motion.

The amendments were voted on first. The amendments of Dr. Workman, to recommendation No. 6, was passed by a large majority. Dr. Robert Wilson's amendment, to recommendation No. 1, was lost by 22 to 14. Dr. Wallace's amendment, as to the time of meeting of the new Board of Health, was passed unanimously. The main question of adoption of the substitute recommendations, as amended, to be recommended for adoption to the House of Delegates, was then passed by a large majority, by the "Committee of the Whole."

The "Committee of the Whole" then reverted to the meeting of the House of Delegates. Dr. Olin Chamberlain then moved, seconded by Dr. W. A. Smith, that the recommendations of the "Committee of the Whole" be adopted by the House of Delegates.

Dr. Gressette of St. Matthews then offered an amendment that the number composing the Board of Health be changed from nine to eleven; to be made up of six physicians, three other specialists and two lay members. The vote on this was tied 28 to 28. The chair voted against it, thereby defeating the amendment.

Dr. W. R. Tuten of Fairfax suggested a supporting amendment to Dr. Gressett's amendment; this also was lost.

The question as amended by the "Committee of the Whole" was then voted on by the House of Delegates and passed unanimously.

Dr. K. M. Lynch moved, seconded by Dr. Chamberlain, that a special committee be appointed, with the President of the Association as chairman, to present these recommendations to the Legislature at its opening session; asking that they be enacted into law. This was passed.

Dr. C. N. Wyatt then moved, seconded by Dr. Lynch, that the changes in the program of the annual meeting at Myrtle Beach, as suggested by President J. D. Guess, be approved. This was passed unanimously.

Adjournment was at 5:40 p. m.

Respectfully submitted,

N. B. Heyward, M. D.
Secretary

DEATHS

GEORGE BALFORD HASELDEN

Dr. George Balford Haselden, 75, retired, died unexpectedly of a heart attack on April 1 at a convalescent home in Lynchburg.

A native of Hemingway, Dr. Haselden was graduated from the Medical College of S. C. (Class of 1911). Following graduation he entered general practice in Hemingway, and later went to Sanford, Fla., and then to Williamsburg where he worked up to the time of his retirement several years ago.

Dr. Haselden is survived by his widow, the former Miss Annie Venters, three brothers and five sisters.

ALEXANDER STEPHEN BLANCHARD

Dr. Alexander S. Blanchard, 74, died in Columbia on April 8 after a protracted illness.

A native of Georgia, Dr. Blanchard was a graduate of the University of Georgia Medical College (Class of 1914). In 1916 he opened an office for general practice in Williston where he worked up to the time of his death. During World War I he served with the armed forces and spent most of his time in France.

Dr. Blanchard was not only a hard working physician but was also a leader in his community. He was active in the Masons and in the work of the American Legion, as well as serving for three terms as Mayor of Williston. He was a loyal member of the Baptist church.

He is survived by his widow, the former Miss Edna Hair, and four stepsons.

BIRTHS

Dr. and Mrs. James C. Shecut of Orangeburg, announce the birth of a daughter, April 1, in Orangeburg.

Dr. and Mrs. Basil Manly of Columbia, are receiving congratulations upon the birth of a daughter, born March 6.

NEWS ITEMS

Dr. Robert A. Gregg is now associated with Dr. William H. Thames of Greenville, in the practice of general medicine.

Dr. Karl Morgan Lippert, Chief of the surgical service of the Veterans Administration Hospital, was banquet speaker at the meeting of the South Carolina Physical Therapy Association held recently in Columbia.

Dr. Rowland F. Zeigler of Florence, has been elected a Founding Fellow of the newly created American Academy of Obstetrics and Gynecology.

Dr. J. B. Galloway has announced the opening of offices in Columbia for the practice of neurology and psychiatry.

Dr. Duncan Pringle was the speaker at the March meeting of the Charleston Pediatric Society.

Dr. J. F. Woods and Dr. L. V. Jowers of Columbia, attended the American Academy of General Practitioners Assembly held recently in Atlantic City.

Dr. Henry Robertson of Charleston, attended the Atlanta Postgraduate Assembly which was held in March.

Dr. D. S. Asbill and Dr. J. B. Workman of Columbia, went down to Savannah recently to attend the Georgia Society of Ophthalmology and Otolaryngology.

Dr. Robert Wilson of Charleston, was in Philadelphia during March for the regular quarterly meeting of the Credentials Committee of the American College of Physicians.

Dr. John M. Preston has assumed the duties of Director of the Richland County Health Department.

Dr. F. E. Kredel of Charleston, was elected president of the South Carolina Surgical Society, at a meeting held recently in Spartanburg. Other officers elected at the meeting were Dr. George T. McCutchen, Columbia, Vice President; Dr. William C. Cantey, Columbia, Secretary-Treasurer. Four new members were voted into the Society as follows: Dr. Jackson Hancock of Anderson, Dr. Lawson Stoneburner, Greenville, Dr. John Hawks, Charleston, and Dr. Harvey McConnell of Lancaster.

DUKE UNIVERSITY POSTGRADUATE COURSE

The annual Duke University Postgraduate course will be held at Duke University, June 16, 17, 18, and 19. Registration fee — \$25.00. Room available in University Dormitory at \$2.00 per day. Meals may be obtained in the Oak Room in the University Union. Meetings will be held in Duke Hospital Amphitheatre. Monday and Tuesday evenings will be spent in informal round table discussions. Daytime sessions will consist of fifty minute presentations followed by ten minute discussion period. No paper or discussion will exceed this time limit.

The distinguished guest of the occasion will be Dr. Ralph Platou, Professor of Pediatrics, Tulane University. Participating with him in the presentations and discussions will be the following members of the Duke University School of Medicine Faculty: Drs. W. C. Davison; J. M. Arena; J. L. Callaway; S. C. Dees; J. S. Harria; L. B. Hohman; E. C. Kunkle; H. Lowenbach; A. H. London; A. McBryde; G. L. Odom; K. L. Pickerell; B. Woodhall.

ELI LILLY AND COMPANY AIDS FLOOD VICTIMS

Eli Lilly and Company, in accordance with its long-established policy, is replacing all Lilly products in pharmacies and hospitals ravaged by the flood in the Missouri and Mississippi River Valleys. Lilly representatives in a dozen states, from Montana to Missouri, have been directed to make the replacement of flood-damaged Lilly pharmaceuticals and biologicals their first order of business. Eli Lilly and Company has been replacing stocks damaged by uninsurable hazards as far back as the 1906 San Francisco disaster.

Along with the replacement of stocks, the Lilly company maintains a reserve supply of typhoid vaccine and other biological products which is kept ready for fast shipment during disasters. The shipping personnel of the company stands by twenty-four hours a day.

As the flood waters recede, the replacement of normal stocks will be made as fast as drug stores, hospitals, and wholesale druggists reopen their doors. In the event of a threat of an epidemic, however, needed drugs are shipped directly to the affected area by the fastest possible means of transportation.

GENERAL PRACTICE POSTGRADUATE TRAINING

The General Practice Group of the University of Tennessee has established a postgraduate clinical training program for general practitioners. This has been approved by the American Academy of General Practice for its members.

The program is designed for the general practitioner on an individual basis, according to his individual needs. One week to one month of training is offered.

Each doctor will spend morning hours in his choice of any one of the University specialty fields. This will be active work at the resident level. The afternoons will be spent in the General Practice Clinic where the medical students get active general practice experience. Evenings are utilized in the emergency room of the John Gaston Hospital which is supervised by members of the General Practice Staff.

General practitioners who would like to participate or who desire further information, may write to the General Practice Office, University of Tennessee, Memphis, Tennessee. There is no fee charged for this training.

EMORY ANNOUNCES POST-GRAD MEDICAL SHORT COURSES

Two post-graduate courses will be offered next fall by the Emory University School of Medicine, it

was announced this week by Dr. Russell H. Oppenheimer, director of medical post-graduate education at Emory.

The courses are expected to attract about 100 physicians each. One, on general medicine and surgery, will run the week of October 6, and the other, on cardiology, the week of October 20. The first is open to general practitioners in the region, and will be given by Emory in cooperation with the Medical Association of Georgia and the Georgia chapter of the American Academy of General Practice.

The cardiology course will be of interest to heart specialists throughout the country, Dr. Oppenheimer declared. Guest speakers scheduled are Dr. George E. Burch, professor of medicine, Tulane University Medical School; Dr. Richard Bing, professor of experimental medicine and clinical investigation, Medical College of Alabama; and Dr. Eugene Stead, professor of medicine, Duke University Medical School.

The South Carolina Surgical Society met in Spartanburg for its fourth annual meeting on April 3rd and 4th, 1952. The membership consists of 34 surgeons in South Carolina of which 30 were present at the meeting. The President, Dr. William H. Prioleau of Charleston presided and the meeting consisted of first the business meeting, then a banquet and an address by Dr. Will Sealy of Duke University after the banquet. The following day there were operative clinics by the members from Spartanburg followed by several scientific presentations.

The following officers for 1952 were elected:

Dr. Frederick Kredel, Charleston -----President
Dr. George McCutchen, Columbia-----Vice-President
Dr. William C. Cantey, Columbia--Secretary & Treas.

The following men were elected to membership:

Dr. Jackson Hancock, Anderson
Dr. John C. Hawk, Charleston
Dr. Harvey McConnell, Lancaster
Dr. Lawson Stoneburner, Greenville

The next meeting is to be held in Greenville in 1953.

WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. K. D. Shealy, Columbia, S. C.

Publicity Secretary: Mrs. Weston Cook, Columbia, S. C.

ANNUAL REPORT

At the beginning of the year 1951-52 the Woman's Auxiliary to the South Carolina Medical Association took as its main objective an increase in membership. The 13 local units, 9 of which are county and 4 district organizations, have all worked to this end and have accomplished a 10% increase in membership over the state.

All 13 local units have worked hard to secure subscriptions to *Today's Health*, and Pickens County won first place in group #1 (membership under 20) in the national subscription contest sponsored by the magazine. Besides giving a tremendous boost to the number of subscriptions in the state, Pickens made almost \$60.00 in commissions beyond the \$40.00 cash prize. Pickens can also boast of the fact that *Today's Health* was placed in every doctor's and dentist's office, every beauty parlor, and every school in the county, a record, we believe.

Realizing the value of our doctors to the community and the state, Doctor's Day, a project of the

Woman's Auxiliary to the Southern Medical Association, was celebrated on or around March 30 with cards, flowers, dinners, dances, theatricals, editorials and other newspaper and radio publicity. In order to preserve the memory of the lives and work of doctors, our county historians have this year collected 60 biographies of deceased physicians. Much valuable information has also been preserved by the chairman of Research and Romance of Medicine, another project of the Southern Auxiliary.

Although some emphasis was removed from medical legislation this year, the Auxiliary has not been inactive. Additional resolutions opposing compulsory health insurance have been secured, and letters to our senators and congressmen have been written thanking them for their stand opposing compulsory health insurance. With the permission of our advisory council the state Auxiliary endorsed a bill to state legislature providing a system of juvenile courts.

Nurse recruitment has been carried on through the local Auxiliary units. With the cooperation of

local hospitals and nursing groups, school assembly programs have been given and movies shown to interest girls in nursing as a profession. Tours of hospitals were conducted and teas for high school girls were given also. Pee Dee Auxiliary awards an annual nursing scholarship in memory of Dr. James McLeod, and loans were granted two girls from our Jane Todd Crawford Memorial Loan Fund for Student Nurses.

The Auxiliary maintains a loan fund for medical students who are the sons and daughters of physicians. No calls have been made on this fund for the past several years, but each member pays \$1.00 annually to this fund. There is now a recommendation to the executive board that the fund be opened to others than the sons and daughters of physicians.

The Auxiliary has contributed to the community welfare through service to the Red Cross, Community Chest, nurses' groups, Crippled Children's Society, Tuberculosis, Cancer, and Heart drives, by showing health movies in schools, sponsoring blood donor days, helping in a maternity shelter, and in one instance helping to organize a local dentists' auxiliary. Local Auxiliary units also helped publicize the essay contest sponsored jointly by the American Association of Physicians and Surgeons and the South Carolina Medical Association. Financial contributions were made to the Red Cross, Tuberculosis, and Cancer Funds, and to the Southern Auxiliary's Jane Todd Crawford Gynecological scholarship fund.

Auxiliary programs have been in keeping with the times, having been on health and Civil Defense. The movies "You Can Survive an A-Bomb Attack" and "Blood and Bullets" were shown. Speakers were heard on Mental Hygiene, Cancer, Crippled Children and Civil Defense. Two unusual and interesting pro-

grams were a panel discussion on "What Every Auxiliary Member Should Know" and a quiz program on Auxiliary organization.

During the year the Auxiliary has lost five members by death, Mrs. Lucia Gaines Shirley of Greenville, Mrs. William Henry Johnson and Mrs. Archie Baker Sr. of Charleston, Mrs. J. C. Harris of Lancaster, and Mrs. P. M. Temples of Spartanburg.

As president of the Woman's Auxiliary to the South Carolina Medical Association I have visited the 13 units, speaking on Auxiliary organization and projects. Having acquainted myself with the work done by the local units as well as knowing the work on the state level, I feel qualified to say that it has been a successful year. The credit for this success belongs, of course, to the local Auxiliaries and to the excellent work done by the executive board.

Respectfully submitted,

Mrs. Kirby D. Shealy
President 1951-52

As president of the Woman's Auxiliary to the South Carolina Medical Association I have had the pleasure and distinction of working with Dr. J. Decherd Guess, president of the Medical Association, Dr. O. B. Mayer, chairman of Council, Dr. Alfred F. Burnside, chairman of our advisory council, Dr. Julian Price, editor of the Journal, and Mr. M. L. Meadors, director of public relations and counsel for the Medical Association. Every courtesy and consideration has been shown to me and to the Auxiliary through the thoughtfulness of these gentlemen, and I take this means of expressing my thanks and that of the Auxiliary to them and to the groups they represent.

Mrs. Kirby D. Shealy

CORRESPONDENCE

TOWN OF BRANCHVILLE

Branchville, South Carolina

Dear Dr. Price:

We are very anxious to get a medical doctor to locate in Branchville and we have been advised by Dr. Kenneth M. Lynch, President of the Medical College of South Carolina to contact you and have you put a notice in the S. C. Medical Journal.

We know that this is a wonderful opportunity for a doctor to locate here as our nearest doctor is St. George or Bamberg which is about 16 miles from here. Branchville has a population of around 1500 and we have a thickly populated area surrounding Branchville which has always patronized a doctor

here. The Town is offering free office space including lights and water and will assist in any other way in helping a doctor get established.

Our only doctor Dr. Basil M. Mixon had to give up private practice here on account of his health and is now working in the Orangeburg Regional Hospital.

We will appreciate you running a notice in the Medical Journal and if there is any cost for it send statement to The Town of Branchville and we will send check for it at once.

Yours very truly,

D. L. Hutto, Mayor
Town of Branchville

THE TEN POINT PROGRAM

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

EXPECT 30,000 IN CHICAGO FOR A. M. A. SESSION

More than 30,000 persons—15,000 physicians and 15,000 persons allied with the medical profession—are expected for the annual A. M. A. meeting in Chicago, June 9-13. Most of the activity will center at Navy Pier, not far from Chicago's Loop. The A. M. A. Technical and Scientific exhibits will be located in this huge structure, which extends more than half a mile into Lake Michigan. Part of the Pier is now used to take care of the overflow enrollment at the University of Illinois. The Pier was completed in 1914 at a cost of nearly five million dollars.

The Scientific Assembly will open with the General Scientific Meetings, Monday, June 9, at 9 A. M. These meetings will be held at Navy Pier, where the registration bureau also will be located. Registration will begin Sunday, June 8, at 10 A. M. At the Palmer House, the House of Delegates will meet for several days, as will various committees and councils.

In the Scientific Exhibit will be found special exhibits and question and answer conferences covering a wide variety of subjects.

A. M. A. members are cordially invited to visit the A. M. A. headquarters during the Chicago meeting. Visitors will be welcome any time from 8:30 A. M. to 4:00 P. M. Guides will be available for tours through the building.

FCDA NEEDS MEDICAL DIRECTORS

The Council on National Emergency Medical Service, A. M. A., has called attention to the fact that the Federal Civil Defense Administration's Regional Offices are authorized to employ full time medical directors to handle medical civil defense problems arising within such regional geographical areas.

In view of the urgency for hiring these medical directors at the earliest possible date, the Council on National Emergency Medical Service is attempting to assist in locating qualified individuals, and has requested the State Medical Societies to cooperate by publicizing information concerning the position, which pays \$10,800.00 per year.

The FCDA Regional Office for Region 3, which includes South Carolina, is located in Atlanta, and inquiries should be addressed to Mr. Wiley L. Moore, Director, Bona Allen Building, Atlanta 3, Ga. Information may be obtained also by contacting the offices of the South Carolina Medical Association, 120 W. Cheves St., Florence, S. C.

According to a general statement of the FCD Administration, such medical director will be re-

sponsible "for providing advice, guidance, assistance and direction to the several states within a designated geographical region and through them their political subdivisions, as regards planning, developing and administering of a program designed to provide health and special weapons defense services to the civilian population during or in the aftermath of enemy attacks."

MEDICAL COLLEGES IN VAST EXPANSION

The greatest expansion program in the history of medical education, to cost \$250,000,000, is now under way in this country.

Almost every college of medicine in the United States is planning to increase its physical facilities. New laboratories, additional classrooms, modern dormitories and special research clinics are on the drawing board or actually under construction.

At present the country maintains seventy-three four-year institutions of medicine, and seven two-year colleges. Commissions or fact-finding committees have been set up in at least ten states to map plans for the development of new medical colleges. Some of the existing two-year schools will be expanded into regular four-year, degree-granting colleges of medicine.

These findings are based on a nation-wide survey conducted by The New York Times, in which the eighty medical colleges and the forty-eight state commissioners of education were reached through questionnaires.

In the current academic year—1951-52—the medical colleges admitted the largest freshman classes in recent history, a total of 7,381 students. The total enrollment has been growing steadily since the end of World War II. Now it is slightly above 26,000, compared with 23,000 five years ago.

Despite the expansions now taking place, large numbers of qualified applicants are unable to gain admittance to any medical college in this country. Many of them seek places in foreign institutions. The records indicate that 20,000 individuals applied for admission to American medical schools for the current college year. As many of them applied to more than one institution, the total number of applications was more than 70,000 or an average of 3.5 a student.

More state and municipally owned medical colleges keep out non-residents than ever before. One-fourth of the schools exclude all students who do not reside in the state, while more than 50 per cent give preference to residents. Some of the medical colleges admit only two or three out-of-state applicants in any

entering class. The Council on Medical Education of the American Medical Association reports that seventeen public colleges do not admit non-residents this year, compared with nine in 1948, seven in 1947 and none in 1946.

Of the total freshman class admitted last year by state and municipal schools, less than 7 per cent were non-residents, compared with 17 per cent ten years ago.

As a result of these geographical restrictions, some of the medical colleges have few students from which to choose. In some instances a medical school is forced to take nearly every one who applies, while other colleges can accept only one out of every twenty or thirty applicants. This makes for uneven scholarship. Whereas A or B students may be turned away in the big-name Eastern private colleges, low B or even C students are accepted in the states that enforce non-resident regulations.

\$50,000,000 for New Schools

According to The Times survey, the medical colleges will spend within the next few years, \$50,000,000 for laboratories, \$30,000,000 for classrooms and \$20,000,000 for dormitories. Another \$100,000,000 is earmarked for research and special projects. In addition, the immediate cost for establishing new medical institutions will run above \$50,000,000, making an over-all expansion program of a quarter of a billion dollars.

The University of Rochester Medical School is planning a \$750,000 new wing to give added space for operating facilities and surgical supplies. The Medical College of the State of South Carolina plans to spend \$800,000 for laboratories, \$1,000,000 for dormitories and \$8,250,000 for special and research projects, including a teaching hospital.

Vast improvements are planned at the University of Michigan Medical School. A \$3,600,000 outpatient clinic will be ready for occupancy this fall, while a \$3,000,000 research institute is also under construction. The college is also seeking \$15,000,000 from the Legislature for a medical science building and \$4,500,000 for a general children's hospital.

New Schools Being Started

To meet the increasing demands for more physicians and medically trained men, at least ten states have taken steps to build new medical schools or expand their two-year basic science schools into four-year institutions. The University of California at Los Angeles completed its medical school, and admitted its first class last September.

The University of Mississippi is proceeding rapidly with its plan to make a regular four-year medical school out of its two-year basic science institution. Dean D. S. Pamkratz of the school of medicine estimates that \$8,500,000 will be needed to expand the physical facilities. An entering class of twenty-

eight is to be admitted each year for the next several years. Dr. Pamkratz said that the graduate work was to be expanded, with special emphasis on general practice.

"We hope to build a rehabilitation center, a new state health department, a large student dormitory, a nurses' home and other ancillary medical buildings in the near future," he added.

The states of New Jersey, Connecticut, Rhode Island, Massachusetts and Florida have appointed commissions or set machinery in motion to found medical colleges. The Legislature of West Virginia authorized the expansion of the West Virginia University School of Medicine to a four-year program, according to present plans.

All of these new medical projects are planned under public auspices. The only medical college under private sponsorship is being founded in New York City.

A \$25,000,000 medical center comprising colleges of medicine, dentistry, nursing and public health is being established under the guidance of Yeshiva University. The center is to be affiliated with the city \$36,500,000 hospital project in the Bronx. According to Dr. Harry M. Zimmerman, director of the new college of medicine, the institution will open in 1953 with an entering class of 100, and will eventually have a total student body of 400. The college plans to spend \$10,000,000 for its basic medical building. A fund-raising campaign is now under way directed by State Attorney General Nathaniel L. Goldstein.

Thirty per cent of the nation's medical schools report that they are unable to get sufficient funds to meet their operating budgets. Many are engaged in campaigns to "keep their heads above water." Forty-five per cent report that they find it difficult to get a sufficient number of qualified faculty members. However, Dr. Zimmerman reports that the college of medicine he heads is experiencing no difficulty in enlisting an adequate staff of competent instructors.

A majority of the medical deans—78 per cent—believe that there is a shortage of doctors in this country at present, and advocate further expansion of medical facilities. Many suggest, however, that the shortage could be alleviated with better distribution. They point to critical shortage in rural areas.

For example, the University of Tennessee College of Medicine notes: "There is a definite shortage of medical service in rural areas. There is also a definite shortage in public institutions, such as mental hospitals and in public health service."

Similarly, Dean R. Hugh Wood of the school of medicine at Emory University observes: "There is unquestionably an actual shortage. The effect is magnified by the additional factor of unequal distribution of physicians."

To Admit More Students

Many institutions are increasing their enrollments to meet the demands from their communities for more physicians. However, Dr. Wood warns that classes of more than 100 may weaken the present high medical standards. Rather than greatly increase the enrollment of existing schools, additional ones should be established, said Dr. Wood, adding:

"One of the present threats to the quality of medical education stems from the fact that members of state legislatures do not understand this point. There have been several instances in the last few years in which the state government has ordered the medical school of the state university to increase its enrollment without providing additional facilities and budget."

Many medical authorities believe that the existing enrollment can be increased without lowering the quality, if sufficient funds are obtained to add to the physical plant and increase the faculty. Every one reached in *The Times'* study urged that the high standards in medical education be safeguarded. (*The New York Times*, Sunday, March 2, 1952)

POSTGRADUATE STUDY EXPENSES

The American Medical Association reports another step in its long fight to get the Internal Revenue Bureau to permit physicians to deduct expenses incurred in the pursuit of postgraduate study from federal income taxes.

Thirty years ago the internal revenue commissioner ruled that a doctor's postgraduate expenses were personal in nature and, therefore, not deductible for income tax purposes. On numerous occasions the A. M. A. House of Delegates expressed the viewpoint that this ruling was in error and urged its reversal, but, to date, all efforts have been futile.

Recently, the A. M. A.'s legal department learned that a case was pending before the U. S. Tax Court in Washington involving the right of a lawyer to deduct expenses incurred by him in taking a special course on federal taxes. Since the lawyer's problem and that of the physician are identical, the A.M.A. filed a brief as *amicus curiae* "friend of the court."

The A. M. A. set out numerous arguments in support of its stand.

The brief said that "in order to maintain and preserve their professional practice, lawyers, doctors, architects, engineers and accountants necessarily engage in a continuous process of education throughout their professional lives. For professionals cannot adequately serve their clients or patients unless their precious fund of knowledge is always kept fresh and intact The expenses of maintaining professional competence easily qualify as deductible business outlays. Obviously, the sums paid are directly connected with a trade or business. They are intimately related not only to the various professions, but to the production of income from those professions."

The brief also pointed out the inconsistency in the Internal Revenue Bureau's stand. The bureau allows a physician income tax deductions for subscriptions to medical journals, expenses of attending professional conventions, dues paid to professional societies, and the costs of professional texts and services. Yet it does not allow deductions in connection with other postgraduate study involving attendance at formal courses.

The Tax Court is expected to hand down a decision in the case shortly.

GIVE THE PATIENT A BREAK

Medical students and doctors have a language of their own. It's a highly-specialized jargon and serves a very useful purpose. We don't say that a patient has chronic inflammation of the lungs caused by the inhalation of mineral dust; we simply say that he has pneumoconiosis. We've used one word instead of twelve—seven syllables instead of twenty-one. But what about the patient who has all this dust in his lungs? Does he know any more than he did when he first had trouble breathing? Let's take another example.

A patient may come into your office covered with pale red patches. He won't know whether he has a rare tropical disease or a minor skin irritation. In any event, he'll probably be scared. He's lived a normal, healthy life and suddenly he's a mass of red blotches. As soon as you've examined him, he'll want to know what's wrong. Tell him he has pityriasis rosea and he'll want to know what that is. It sounds pretty bad to him. If you tell him that it's a self-limited skin disease, that you don't know anything about the etiologic agent but that you can probably cure him by empirical methods, you've made a nervous wreck out of a patient that probably would have recovered if he'd never come to see you.

Unless he insists on knowing the scientific name for his malady, why floor him with something as deadly-sounding as pityriasis rosea? Why not tell him he has a skin disease which is relatively rare but seldom serious and that you can probably clear it up with ultraviolet treatments? Tell him that there's very little chance that his wife and four children will catch it and that it would have gone away eventually even if he hadn't come to see you.

Instead of a doomed man, you have a grateful patient. Perhaps he'll try to remember the "long name" and get some undeserved sympathy from his wife. But isn't that better than sending a man out of your office who felt pretty good an hour before and is now going home to read his will?

Whether it's pneumoconiosis or pityriasis rosea, tell him, in his language, exactly what's wrong. These explanations may be time-consuming but imagine how you'd feel if someone told you that you had advanced pheriod stiemeremia. Let's give the patient a break! (*Journal of the Student AMA*, April, 1952)

CHANGES IN THE MEMBERSHIP AND FELLOWSHIP STRUCTURE
OF THE AMERICAN MEDICAL ASSOCIATION 1919-1952

1918 to 1949

Prior to 1950, and since the year 1918, all physicians who were members of their State Society were non-dues paying members of the American Medical Association. Of the 144,211 members of the A. M. A. in June, 1949, 77,723 were listed as fellows. Fellows paid dues to the A. M. A. and received THE JOURNAL A. M. A.

1949

The House of Delegates of the A. M. A. assessed all members of the A. M. A. \$25.00, but this assessment was voluntary and not compulsory. This was the only assessment made.

1950

There was no assessment in 1950. The A. M. A., for the first time, set the dues for membership in the A. M. A. at \$25.00 a year. If these dues were not paid by the end of the year the member was dropped for non-payment; before he could be reinstated, it was necessary for him to pay the delinquent year's dues. The 1950 dues did not include a subscription to THE JOURNAL A. M. A. A member in 1950 again had to pay fellowship dues to receive THE JOURNAL A. M. A., or could subscribe to it separately.

1951

The membership dues in the A. M. A. in 1951 were \$25.00 and included a subscription to THE JOURNAL A. M. A. Fellowship dues were reduced but no longer included a subscription to THE JOURNAL A. M. A.

1952

The same as 1951, except that there are no fellowship dues and fellowship cards are not being issued. Fellowship will probably be abolished after the Annual Meeting of the A. M. A. in June, 1952.

The following summary will further clarify the changes from 1949 to 1952:

MEMBERSHIP IN THE AMERICAN MEDICAL ASSN.	FELLOWSHIP IN THE AMERICAN MEDICAL ASSN.	SUBSCRIPTION PRICE OF THE JOURNAL A.M.A.
Membership dues in the A.M.A. never included Fellowship dues. Membership dues have been payable only through the County and State Societies.	Fellowship in the A.M.A. was dependent upon membership in the State and County Societies and the A.M.A. Fellowship dues were payable to the A.M.A. and were in addition to the membership dues.	Since January 1, 1951, the price of THE JOURNAL has been included in membership dues; rates below for 1951 and 1952 are for non-members, and laymen. Anyone may subscribe to THE JOURNAL.
YEAR		
1949		
Assessed \$25.00 but payment not compulsory.	Dues of \$12.00 included THE JOURNAL A. M. A.	\$12.00
1950		
Dues of \$25.00 did not include THE JOURNAL.	Dues of \$12.00 included THE JOURNAL.	12.00
1951		
Dues of \$25.00 included THE JOURNAL.	Dues of \$5.00 did not include THE JOURNAL.	15.00
1952		
Dues of \$25.00 include THE JOURNAL.	No fellowship dues for 1952.	15.00

1952 IS THE YEAR OF DECISION

So says the Medical Society of New Jersey and in a recent membership letter offers this comment:

Nothing is more repugnant to irresponsible people than inescapable responsibility, nothing more distasteful to the weekly vacillating than the necessity for strong and definite action.

This year upon which we are now entering is destined to prove, for all times, the character of the American people. In this year of Presidential election either we will demonstrate that we are a thoughtful, vigorous people of dedicated and lofty purpose, or we will reveal ourselves as muddle-minded and indifferent, ready to tolerate and even to assist the agencies of our deterioration and debasement.

For the preservation and continuance of our national life and character we are called upon in 1952 to act. We shall need all the best of wisdom and courage that good men can muster and God can give. If we cannot meet the challenge of these critical times, it may well be that we shall never know again the privilege of free choice. Should we this time fail

as articulate, free men, we must be prepared henceforth to drag out our lives as voiceless slaves.

The members of the medical profession have a double duty, as doctors and as citizens, to do all that they can to influence public opinion and action in the interests of the common good. The question to be answered is not "What kind of medicine shall we have to practice in the America of tomorrow?"—but "What kind of America shall we have tomorrow to practice medicine in?" 1952 will in large part supply the answer.

A total war is being waged. Our adversaries are united, determined, devious, and relentless. Should they win, we, the citizens, will hereafter serve the government instead of having the government serve us.

Ours is still the power of free decision. This year we are called upon again to employ it. Shall history record that we exercised this privilege wisely and well in 1952, or will it report that we used it for the last time? (Reprinted From Rocky Mountain Medical Journal, March 1952)

LIFETIME ACCIDENT INDEMNITY TWO YEARS SICKNESS INDEMNITY FOR PHYSICIANS AND SURGEONS

Eighteen Years of Satisfactory Service to the Medical Profession

HERE IS A POLICY WITH NO TECHNICALITIES

Incontestable after one year, as to origin of disability.

No age limit, if policy is purchased before age 60.

No house confinement required.

Non-cancellable for period during which premium is paid.

Loss of Time: Pays \$400.00 per month for Total Disability due to ACCIDENT	LIFE
Loss of Time: Pays \$400.00 per month for Total Disability due to SICKNESS up to	\$9600.00
Hospital or Graduate Nurse at home, \$200.00 per month, additionally, up to	400.00
Surgeons Fees: If your injuries require a doctor, but cause no loss of time, bills are paid, up to	100.00

INDEMNITIES MAY BE PURCHASED AS ABOVE
OR FOR SMALLER AMOUNTS

WRITE

RALPH GOLDEN

LEE FENTRESS, JR.

BOX 2792

INTER-OCEAN INSURANCE COMPANY

316 JEFFERSON STANDARD BLDG.

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Medicine's Tragic Failure*

By

J. DECHERD GUESS, M. D.
Greenville, S. C.

That medicine has made and is making tragic mistakes is evident everywhere. That these mistakes have resulted in failure of the profession in a field that is of the greatest importance to our prestige and to our usefulness is generally acknowledged. These mistakes and their resulting failures lie in the area of public relations, which is another way of saying that they involve the physician-patient relationship. Our admission that they exist is found in the employment of directors of public relations by many medical groups. In an earlier day, every doctor was his own public relations expert, and his failure in the field of public relations injured himself but had little effect upon the profession as a whole. Such is not the case in these modern times of easy communication and fast travel. One man's failure, or the failure of a small group, is widely publicized and hurts us all. It is my belief that the basis of the antagonism which is directed against us as a group lies not in group relationships with the public, but rather in the individual relationship of the physician with the patient and the patient's family. If this is true, relief from an unfortunate situation can come only from doctors acting as individuals rather than acting in groups through a public relations director. Such a director can serve in two important roles. He, by study and investigation, can search out the actions and attitudes of doctors which result in poor public relations, and he can serve as a mouth-piece to publicize the steps taken by members of the group he represents to correct those actions and attitudes which bring about antagonism.

Organized medicine, both state and national—less often county and city groups—has been subjected to attack and vilification. The American Medical Association is not infrequently referred to as a medical trust. The practice of medicine has been declared a business, subject to federal antitrust regulation. In our own state, The South Carolina Medical Association seems to have lost much of its influence.

Efforts of organized medicine have met with little cooperative response by leaders of non-medical

groups. The Blue Cross—Blue Shield movement is ridiculed and belittled by many labor and political leaders. The South Carolina Parent-Teachers Association declined to consider a resolution against socialized medicine, and the Council of the State Nurses Association would not allow such a resolution to be introduced. Many educators in both colleges and public schools have openly advocated state medicine and ridiculed medical practice as it now exists.

The loss of widespread and powerful influence by the profession has not been due to a lack of interest in the science of medicine and its marvelous progress. Such interest was never before so general and so intense, nor has popular medical knowledge ever been more prevalent. Neither is the loss of public esteem due to lessened respect for the accomplishments of scientific medicine or for its ability to shorten illness and to lengthen life. Scientific medicine is loudly acclaimed by the most lowly and by the erudite. Medical care is sought just as eagerly as ever, although, perhaps, more critically.

However, widespread knowledge of the accomplishments of modern medicine has not lessened the patronage of the various unlearned medical cults, nor did that knowledge together with the antagonism of the medical profession prevent the passage of practice acts, making cultic practice legal. Cultic practitioners cannot depend upon scientific knowledge to attract and to hold their patients. Even though we may consider these people quacks and frauds, they appear to have something that many people like better than what we doctors give them.

The antagonism of the public is not directed against medical science and medical skill. It is directed against the doctor as a man and as a citizen. Its attitude toward organized medical groups is very much the same as that which many people have toward labor unions. Their idea seems to be that mercenary, though scientific doctors are banded together to further selfish interests. Doctors have become, to many individuals, impersonal purveyors of medical service on a fee basis very similar to that of any artisan.

*President's Address, The Annual Meeting, South Carolina Medical Association, Myrtle Beach, S. C., May 15, 1952.

It is time that an effort be made by us, both as individuals and as organizations, to ascertain why this change in attitude has occurred.

It is my belief that the basic cause of the public's changed attitude toward the medical profession stems from its reaction to changed attitudes and interests of the individual doctor. I believe that changed attitudes and interests of the doctor have in turn resulted from his broader knowledge of medicine and the greater medical knowledge of the public. In both instances, the seemingly great knowledge may be faulty but still satisfying. Let me illustrate. If a doctor, after brief questioning and cursory examination, makes a diagnosis of common cold and gives a dose of penicillin, he may be quite satisfied with his diagnosis and his treatment and so may be his patient, even though penicillin has not been found of value in treating common colds. However, the doctor has no necessity to fear exposure of ignorance or to convince the patient that the treatment is quite correct and up-to-date. If the patient should have pneumonia instead of a common cold, no harm will have been done. Almost the same attitude might be taken in case of suspected appendicitis, whether the suspicion be by the doctor or by the patient. Hospitals and surgeons are available, the operation causes little inconvenience, and one is better off without his appendix anyway. So why waste time in careful examination and in discussion and argument. Instead, let's get ahead with the business and pass on to the next patient.

These attitudes and procedures are very different from those of a former day not so long ago. Then the doctor had no technical assistance, nor did he have usually much technical equipment. A diagnosis could not be made from a report. It had to be made by mental and physical effort, and it had to be convincing to him. It frequently could not be made hurriedly, and often required more than one examination. The diagnosis had to be convincing to the patient also, and to make it so required a show of personal interest, an air of unquestioned knowledge and a considerable bit of conversation. Interest, exposition and display of knowledge, with explanation and direction, required more or less prolonged contact. If things did not go well, if the diagnosis proved to be faulty, if complications developed, it was the doctor who suggested and determined specialist consultation and laboratory examinations. Frequently the doctor's greatest recompense was gratitude. He rarely sent a bill, and if he did, he rarely demanded an adequate fee. To say that he was a poor business man is not an adequate description of him. In business, his ability was frequently recognized and his advice sought after. But practice of medicine was not to him a business. In it he was a kindly, loving, interested friend, pursuing a treasured vocation, and as such, he was not only respected, he was loved.

Today, the doctor lives in a different world, and his people are a different people. Leisure is gone.

Aspiration for his own comforts and for comforts and privileges for his family press upon him. He needs money to provide these things. He needs money to maintain his office establishment with its expensive equipment and high salaried technical assistants. He must see many patients in a day, and therefore he must delegate as many tasks as possible to his assistants and must utilize diagnostic aids applied by them. He convinces by display of examination reports, and his therapy is ordered with dispatch. It usually satisfies his semi-informed patient—but there is not time for interaction of personality upon personality, little time for display of personal interest, and no effort made to satisfy the *soul* of the patient. The doctor is almost as impersonal as the technician who made the blood count.

We hear and read much of the complexity of the times and the resulting prevalence of emotional conflicts, and of the influence such conflicts have upon disease, and yet we do not take time to learn of such conflicts in our patients and to attempt to resolve them as best we may.

Every person needs a physician-friend, a friend to whom he can come with all of his medical and emotional problems — not that he could or would expect him to treat all of his ailments. People are too smart to expect that—but someone to turn to for advice as to where and when to go, and for comfort and sympathy. Family doctors have ever claimed that function, and specialists have rather haughtily renounced it. Theoretically, perhaps, both are right in their attitudes. Actually, they are both wrong. The family doctor does have the opportunity or may cultivate the opportunity to act as counselor and trusted friend. But too often in the rush of the day's work and at times its recreations, he has pushed aside, sometimes ruthlessly, such opportunities. On the other hand, there are specialists, who sense the need and find the time to be the personal physician to many patient-friends, even though he limits medical treatment to that of his specialty.

Deterioration of public prestige is the result of deterioration of the mutual relationship between physician and patient, and it is a psychological problem which can be solved only by a psychological approach. The California Medical Association, which has many times exhibited impressive initiative, seems to have recognized that fact. It, in collaboration with its Alameda County Society, has recently reported the conclusions of a psychological study. Dr. Ernest Dichter, a practical psychological consultant to large businesses and industries, was employed to conduct a research study of "existing voids between medical ideals and practical problems of private practice" using Alameda County as a laboratory. An interpretation of Dr. Dichter's report was prepared by Rollen Waterson, executive secretary of the Alameda County Society, and William Tibbits of the Orange County Society. Their analysis was published in the October,

1951 number of "G. P." This seventeen page article should be read by every doctor, and it should be studied carefully by every director of and by every committee on public relations. The report revolves around the idea that medical public relations are determined by individual human relationship between doctor and patient. The study concerned the psychological factors inherent in the physician-patient relationship, and the report gives a new insight into individual human relations that make up the public relations of medicine.

The authors of the analysis write: "Broadly stated, Dichter's study reveals that medicine has lost its 'historical heritage' of community devotion and leadership because the doctor-patient relationship has not changed to fit comfortably into the continuously changing pattern of life."

Let me mention briefly some of the elements of this failure, as related by Dr. Dichter, and the remedies suggested by him. The ideal doctor of the people, says Dichter, is the family doctor of tradition, but in modern thinking, he is the *personal* physician. Everyone desires a relationship with the physician of which he is the patient, whether sick or well, and the doctor is his personal doctor. Such a physician will willingly accept total and continuing responsibility to the patient for either administering or securing and supervising the best available care for all medical and surgical problems. It is my feeling that not only general practitioners but also specialists, except those with very restricted fields, can and should do just that for those patients who show a desire for such a relationship. Too often patients are brushed aside without sympathy or guidance with the statement, "That is not my field." The idea of and desire for a personal physician implies a continuity of interest and relationship; Dr. Dichter believes that the patient is then aware of the doctor's affection and has affection for his doctor. The patient is a participant in his medical care rather than a recipient. He states further: "It has been observed that these practitioners (who maintain the relationship with their patients which has been discussed) are most often the ones who carry their full share of community responsibility, are informed and leading participants in community affairs, and their patients, because of the sum of all these things, are satisfied with their doctor, often enthusiastic about him, and generally feel well disposed toward the medical profession as a whole."

He thinks that with the increase in medical knowledge and specialization, and as patients became specialty conscious, the family doctor came to feel on the defensive; and the phrase "just a general practitioner" became a self-applied designation of littleness as compared with specialist bigness. Patients accepted this, and as the family doctor lost patients to the specialists, he lost his exclusive position in the hearts and minds of his patients. In reaction, too many family doctors retaliated by refusing to refer patients to or to consult with specialists. Although the patient

recognizes the value of specialization, he still feels a need for an "advocate, a friend in court, a counselor, a family doctor—a personal physician." He thinks that the jealousy and antagonistic attitude of the family doctor toward specialists have driven many patients away from his office—patients who craved his interest and guidance.

The idea of the personal physician as conceived by Dr. Dichter is more restricted in application and is yet as broad in its service as was the traditional family doctor. Each member of a family might have a different personal physician with a relationship as intimate and as affectionate as that between the family and the family doctor in days gone by.

In the rush of medical advancement, which has made curable diseases that before were nearly or quite incurable, which has eased pains which before could not be alleviated, which has shortened convalescence and has extended the span of human life, medical doctors have been caught up in a sense of achievement and of self-confidence that is unparalleled. In spite of that feeling of elation, based on those successes, doctors have made a tragic mistake, which has deprived them of the love of their people and has supplanted the doctor's love for them. The mistake has been not only an individual one. In too many instances, it has been collective. Only both individual and collective action can correct it. Every organized medical group should initiate studies of physician-patient relationship, similar to those begun in California. It would be wise for every doctor to study his own attitude toward and relationship with his patients and with the people in his community, with the aim of winning back their affection and their appreciation, if it seems that they have been impaired. Let doctors cease to be so interested in a case or a symptom, that they forget the patient as an individual. Let them not forget the emotional life of the patient in their quest for tissue pathologic changes, and let them no longer dismiss the patient as a neurotic when no such changes are found. Let us recognize that the ego craves affection for itself and craves to bestow affection upon others. Let us constantly bear in mind that a long life without love and respect is a life not worth living, and that applies both to our lives and to the lives of our patients. Let us find time in our busy days for altruistic interests and activities, in addition to the application of medical science to cases. When we have brought ourselves to do this, our lives will be fuller and richer, and we will find that once again we have reestablished ourselves in the love and confidence of the people. If we fail to do so, then the time will come, and within the lifetime of many of us, when we will be civil servants, controlled and directed by a federal bureau, our services demanded and received as a citizen's right rather than as a privilege, and our remuneration fixed by law and paid by the government. Under such a system, neither doctor nor patient will be happy, and neither doctor nor patient will profit.

Bilateral Polycystic Ovaries

ARTHUR J. KATZBERG, M. D.
Newberry, South Carolina

Large series of cases are difficult to obtain even from active gynecological services and, consequently, to date the literature is not overburdened with reports of this interesting condition. It is because of the above that I take the liberty of reporting on the few cases I have seen as a private practitioner. These cases came to my attention complaining of amenorrhea and sterility.

Here we are dealing with an old problem that has only recently been recognized. The pelvis has for years been the playground of the occasional surgeon and many general practitioners. Even the well qualified surgeon and gynecologist have been guilty during the phase of surgery when the ovary was the victim of attack against vague and unexplained female disorders. Ovarian cysts were punctured, stabbed, incised and excised with such poor therapeutic results that one hesitated to admit to such procedures. It was in 1925 that the polycystic ovary was described by Edward Reynolds, but this view was not accepted—probably because of the trend away from ovarian surgery. Stein and Levinthal in 1935 demonstrated that the polycystic ovary was no myth and called attention to a syndrome associated with these ovaries.

Many reasons have been given for the development of non-neoplastic ovarian cysts. In the early 1900s, chronic infection of the ovary was considered as the cause. In the 1930s, some European workers suggested dysfunction of the sympathetic nervous system. It was later proposed that persistent Graafian follicles gave rise to a functional disturbance or, perhaps, from pressure of the repeated follicle formation without luteinization. It has also been noted that anterior pituitary hormone injections in laboratory animals and some humans produced an increased number of follicles, some of which remained as cysts. Work in 1947 by Reynolds and in 1949 by Delson rediscovered the part played by the ovarian spiral arteries and their influence on the development of ovarian cysts. It is all very confusing, but perhaps out of this confusion will come some simple explanation.

It is not difficult to recognize these ovaries on gross examination. They are usually enlarged, but rarely more than five times normal, without distortion of the shape. The surface may be white with a smooth surface or may give the appearance of tapioca in a transparent white balloon. No recently ruptured follicles or corpora lutea are seen. A cut section reveals a thick white skin, the tunica albuginea. The contents are tapioca in appearance with multiple cysts and a dense stroma.

There is no clear-cut diagnostic picture in these cases. There are, however, enough clues to make one think of polycystic ovaries and stimulate the search. Menstrual abnormality is almost always present and, in the vast majority of the cases amenorrhea is the abnormality, with menometrorrhagia as a part of the history as a past or present episode in some instances. Sterility is almost always a complaint. Long periods of amenorrhea that have not responded to any of the recognized forms of treatment, plus sterility, should arouse suspicion. Hirsutism is frequently present as is also obesity, although these are more often absent than present. If pelvic examination reveals bilaterally large smooth ovaries, the diagnosis is complete enough to warrant surgical intervention. In some cases, it may be necessary to resort to hysterosalpingogram combined with carbon dioxide pneumoperitoneum or culdoscopy to convince one that polycystic ovaries are present.

Treatment of this condition has been hormonal, which has been for the most part uniformly unsuccessful. Stimulating x-ray therapy, which too has been tried, is not of any real value, and surgery which offers the only real solution at the present time.

The surgical procedure most beneficial has been removal of a large wedge-shaped portion of the ovary, followed by suture of the capsule. Turning the ovaries inside out has been successful, but it is followed too frequently by postoperative adhesions. Taking into consideration the fact that the reason for the surgery is to relieve the tension of the capsule and to permit escape of the ovum, I varied the operative procedure. The first step, or excision of a wedge-shaped area, was done as usual, but instead of suturing the capsule, a strip of gelfoam was placed in the excised area and one mattress suture in the capsule was used for pressure to control bleeding. In this manner, I hoped to leave an avenue of exit as well as prevent a recurrence of a closed, tight thickened tunica.

Three cases of bilateral polycystic ovaries were operated upon, using this method. The diagnoses were confirmed by pathological reports. All three cases complained of amenorrhea of at least one year's duration, sterility of at least two year's duration, hirsutism and obesity. One patient had an early history of menometrorrhagia. All these patients had had extensive hormonal therapy with no results. Two patients had their first normal menses within fourteen days after surgery and have continued to have normal menses for a period exceeding eighteen months. The third patient did not have a normal period until three months had elapsed. This last patient is the most

interesting because pregnancy occurred after the first normal menses. Placenta previa made it necessary to perform a cesarean section shortly before the estimated date of confinement. An inspection of the ovaries showed no adhesions with a small opening at each pole of the ovaries. It is difficult to say how long these ovaries would remain open since only thirteen months had passed since the time of the original surgery. It is very probable that, over a long period of time, the entire area would be filled in by ovarian of scar tissue.

A minor variation in the surgical treatment of polycystic ovaries is presented. It would be of interest to perform similar animal surgery in a large series of cases to determine the fate of the surgical opening in the ovary over a long period of time.

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The Problem of Nutrition in the Conduct of Public Welfare Work

F. A. DEAN
Chief, Division of Public Assistance
Department of Public Welfare
Columbia, S. C.

(It is our policy to publish occasionally a paper or study dealing with some phase of medical care or welfare, prepared by someone who is not a member of the medical profession. Thus, physicians are given the opportunity of seeing old problems from new angles.

In this paper, which was presented at a recent meeting of the South Carolina State Nutrition Committee, the problem of nutrition—and malnutrition—is presented through the eyes of one experienced in the field of public welfare work in a state governmental agency. It should stimulate doctors to renewed interest in the work of preventive medicine. Editor.)

I want to talk to you about nutrition as seen from a public welfare department viewpoint. I know that much of what I say will not be new information to you. In fact, it will be somewhat like carrying coals to New Castle, because I'm sure that you who specialize in the field of nutrition know far more about the subject than I do. However, we people who work with the welfare department have to know a little about everything that affects the lives of people, because we are interested in the total welfare of the individual and his family.

The effects of proper nutrition on the individual from the cradle to the grave is one of the most important factors we have to consider, and I hope to show as we go along just why this is true. I know that we would accept this statement as so true that it almost need not be said, but I am afraid that our acceptance is largely academic. We in the welfare field have ample opportunity to observe the tragic results of malnourishment—we don't have to read a book about it, we see its devastating effects day in and day out.

Now, I should like to follow up this cradle to the grave theme with some facts I have gathered and some illustrations and statistics. The need for proper nutrition really antedated the cradle, because from the time of conception the individual's life begins to be influenced by the food he gets. I am sure that you are all familiar with the results of some research done by a group at the Harvard Medical School. According to their findings the chances of an infant being born well formed and in good health was four times greater when the mother's diet had been good, and the chances of starting from the cradle handicapped with poor health was twenty times greater when the mother's diet had been poor.

According to some of my friends in the health department, 1,711 babies were born prematurely in South Carolina during 1950. It is recognized that poor diets of expectant mothers are a contributing cause of premature birth. We have in our state one of the highest maternal death rates in the nation, and the leading causes of these deaths, toxemia and hemorrhage, are associated with poor food habits. We see then that the individual runs a great risk from poor nutrition even while in the protected environment of his mother's body. When he is at last laid in the cradle he begins to fight the battle of life on his own. With his feeble equipment he has to overcome the stupidity and ignorance of those on whom he is dependent. From our observation the battle does not go too well with the children in this state. According to some very excellent surveys and studies made by certain members of this committee, our children do not compare favorably with those of other sections

from a health standpoint, and this poor showing may be traced to lack of proper food or to poor food habits. I think that these studies show that poverty plays a large part in our children's failure to get the quantity and kind of food they need, but ignorance and just plain "don't care" go hand in hand with poverty. I think I can illustrate this by citing a case. In one of our counties there lives a family consisting of the father, 50 years old, the mother, 40 years old, and eight children ranging in ages 20 to 2. We have had some contact with this family since 1938. During these years the father has been a chronic complainer with pains in various parts of his body, the mother worn out with no energy to do the tremendous job of caring for a large family. We gave financial assistance for a time, but the family seemed to get nowhere. Finally we decided that financial assistance was not the answer to this family's problems. We knew that the home and 185 acres of land were owned; we felt that this family should be self-supporting. However, we could not forget these children so the case was referred to one of our child welfare workers for whatever service she could give. She began by having the entire family given a thorough physical examination. The results showed that the father's vague pains of the stomach and head was due to a malnourished condition resulting from long years of poor food habits; the mother was in a similar condition, no organic disease, but listless and without energy. Two of the older children were in fair health but underweight, two of the children were infested with hook-worm, and the four youngest children were found to have defective vision. It was obvious to the worker, had the doctor not told her, that the problem was one of proper nutrition for the whole family. The four children with defective vision were carried to a specialist. When he examined them, he threw up his hands and said, "I can't do anything for these children in their present malnourished condition; take them and feed them milk, fresh meat, vegetables, and fresh fruit for a year and bring them back." This was a large order, but the worker went valiantly to work. She enlisted the help of several agencies including the home demonstration agent. Some money was obtained from county emergency funds, milk was obtained through a community source (no cow was owned) and by hook or crook some vegetables and fruit were obtained. At the end of the year the family showed great improvement. The father felt so much better that he put in a crop of 30 acres and had developed a good garden. The mother was a different person. She was taking more interest in her children, and had learned the importance of preparing the right kind of food for her family. When the four children with visual defects went back to the doctor they were much improved, but it was necessary to fit three of them with glasses. This family is now in much better health and is self-supporting. This case illustrates the effect ignorance about food can have on a family. We were lucky enough to do something about this one, but there are thousands of others that do not get this sort of special-

ized attention, because we do not have many workers who have time to do intensive case work with families. Then, too, I question that this business of coming in and picking up the pieces after the damage is done is the answer to the problem. It seems to me that it is essentially a question of education, and it is a question which is not answered by the teaching of home economics in school—although this certainly is a help. We need some more effective way of getting at the family in the home itself. I know that we have some very fine home demonstration agents and other workers in the extension field, but it has been our observation that those who need it most are not touched directly by those workers or anyone else. The poor and ignorant will not come to meetings. In the first place they don't know enough to have any desire to come, and in the second place they would feel ill at ease in the company of some of their more prosperous neighbors. We need to devise some means of going directly to them. The Department of Public Welfare has under its care 20,000 children in 5,000 families. A great majority of these families do not get enough to eat because they can't get it with the money they have. They certainly need help in spending what little money they have in obtaining the right kind of food.

It would be hard to calculate the money the State would save by doing more preventive work in the field of nutrition. A great many of these children who grow up under submarginal conditions do not succumb to illness during childhood, but at some time during their adulthood they begin to have all kinds of health problems. The money spent on medicine, doctor's bills, hospitalization, and public assistance is staggering. The Department of Public Welfare has assistance programs designed to care for people from the cradle to the grave. We do the best we can with the young people, but our best is evidently inadequate because our program for handicapped and disabled people shows that a great many people are broken in health before they reach old age. Not all of this poor health can be traced to malnourishment directly, but I would venture to say that it is a contributing cause in a majority of the cases. At the present time the State is supporting over 6,000 individuals due to broken health—most of these are grouped in an age group of between 55 and 65. Over 4,000 of them are totally and permanently disabled. A recent analysis of the causes of disability showed only about 2% diagnosed as due to nutritional deficiency, but among the major causes found were heart disease, hypertension, arthritis, diabetes, and arteriosclerosis. How many individuals succumbed to these diseases due to run-down systems we can only imagine. It will cost the tax payers \$1,500,000 to support these disabled people this year. There are 42,000 people over 65 years of age and 1,500 blind people being supported through public assistance at a cost of around \$14,000,000 a year. There are 4,000 people on the blind register. Many of these people would still be leading productive lives had they been provided with food to

build strong and healthy bodies while they were growing to maturity. My business is administering public assistance and you can see that it is big business. However, I firmly believe that my business would dwindle away if one-tenth of the money we spend in trying to pick up the pieces of human wreckage were spent in

preventive measures. We are not experts in the field of nutrition, but we have become experts in observing the need for proper nutrition. We are willing to cooperate to the fullest with those of you who are experts in trying to do something about this problem. It is a challenge which I should like to leave with you.

"Your Rheumatic Fever Program in Action"

M. W. BEACH, M. D.
Charleston, S. C.

In a previous communication we informed you concerning the establishment and purpose of the Rheumatic Fever Program, and stated that it was set up according to the general principles and policies outlined by the Crippled Children's Division of the Children's Bureau of the Department of Labor. The purpose of the program was to find out if there were any Rheumatic Fever patients in a limited area of the State and to determine if there were a need for continued diagnostic and therapeutic services. Since the program was to be one of demonstration and since the budget was limited, the area to be screened was confined to five (5) counties in this section, the health units of each county agreeing to assist in case findings and follow-up care. Because of the facilities and personnel of the Medical College and the availability of Roper Hospital and the Crippled Children's Convalescent Home in Florence, headquarters were established in Charleston.

The program is administered under the supervision of the Crippled Children's Division of the State Board of Health. Part-time services of a pediatrician, who is director, an assistant pediatrician, a consultant cardiologist, a roentgenologist and the full time services of a public health nursing consultant, a medical social worker and a clerk, are paid for by the Crippled Children's Division.

Children and adolescents under the age of twenty-one (21) years are eligible for the diagnostic, treatment and follow-up services of the program. If hospital care is necessary the patient is admitted to Roper Hospital. Convalescents who cannot receive adequate care at home are frequently placed in the Crippled Children's Convalescent Home in Florence.

During the eight (8) years that the program has been in operation there have been some interesting developments. As physicians, nurses and social agencies, school teachers and the public in general have become informed about the program they have grown interested and the laity are anxious to participate in this clinic. However, there is urgent need for a closer contact with parents of the pre and school age children. By education and screening of this

group, I am convinced that a larger number of active and early cases could be found. With proper treatment and follow-up, one could restore most of these cases to health and happiness, which would enable them to become productive and useful citizens. Several physicians have been willing to refer all their suspicious cases to the clinic, for either diagnosis or treatment. Private patients are not followed by the clinic unless requested by the referring physician. There has been some skepticism on the part of a few practitioners concerning the necessity or value of the program, for they do not believe that Rheumatic Fever is very prevalent or a health problem in this state. Patients have come from most of the counties of the state but on account of limited funds and the scarcity of trained personnel, we have been forced to limit our activities to the lower third of the state. I am convinced that there is evidence to prove from a public health standpoint, the desirability of re-establishing adequately supported clinics in the other two-thirds ($2/3$) of the state. Then, an effort could be instituted whereby the unfortunate Rheumatic victims in these districts could be located and a diligent effort made to restore them to health and usefulness before the debilitating symptoms of this disease have become dangerously evident. If this type of prophylactic medicine could be offered to more of our juvenile rheumatics in every county of the state, I am confident we would have less chronic cardiacs, who by this time have become a liability instead of an asset to their community.

You probably know that the source of patients for this clinic are the County Health Departments who by a special medical form certify and register them with the Crippled Children's Division, and if acceptable, a copy of this form is referred to this clinic. We then give the patient an appointment for examination. The patient's history and social environments are evaluated and a complete physical examination is done and laboratory procedures performed. When all these reports are available the patient's records are reviewed and conclusions drawn in accordance with the accumulated data. Sometimes it is impossible to arrive at a definite diagnosis from

this first visit and further examinations and study are necessary before we can confirm or deny the existence of Rheumatic Fever. So that these patients may have a thorough examination and all the necessary laboratory procedures that may aid in arriving at a correct diagnosis, these facilities are available to the clinic at a very nominal fee. Therefore it is possible for our staff to give these patients an adequate examination during their first visit. Should there be extenuating circumstances necessitating further observation, examination and special laboratory procedures, we may then hospitalize these patients for this purpose. Since these patients come from the lower income group and since it would be impossible for them to struggle with the added financial burden in this undertaking, the Children's Bureau through the State Board of Health, is financing this study in the Rheumatic Fever Program.

After the first visit and after a tentative diagnosis of Rheumatic Fever has been made, the staff discusses what type of therapy would be most appropriate for the individual patient. If this form of treatment can be methodically administered by the parents, with the assistance of the visiting nurse, in the home, the patient is confined to bed and the recommended form of therapy is instituted. Usually the patient is given enteric-coated sodium salicylate—one (1) grain per pound body weight per 24 hours. This amount is divided into three, four or six doses. It will in a few days raise the salicylate level in the blood approximately 25 to 35 mgs. %. The optimal amount in the blood for therapeutic response appears to be that level just below the point of mild intoxication. The follow-up nurse is alerted in reference to the early evidence of sodium salicylate intoxication so that she may know when to discontinue or decrease the amount of the drug to be taken, and to consult the clinic for further advice concerning the patient's welfare. Sometimes the home conditions are very meager and does not add to the well-being of the patient, who should at least have a separate bed and be somewhat protected from the other members of the family, who are frequent carriers of respiratory infections. Also in this type of home, bath facilities and sanitary conditions are unsatisfactory. The want of adequate food and overcrowding add to the burden of the patient and may be the deciding factor against further efforts at home treatment. If the case be an acute one, and cannot be managed at home, he is hospitalized at Roper Hospital and treated until he appears to be in the inactive phase of this disease. Then if further care is imperative and cannot be had at home, an effort is made to place this patient in the Convalescent Home at Florence where it may be necessary to maintain him for many months. During this time every effort is made to bring about a state of well-being so that he may stabilize himself in the inactive phase of this disease. While at this institution it is possible for him to continue with school and vocational activities so that he may return home prepared to fit into that particular pattern.

After the patient has been rehabilitated and established in his former environment, the health nurse visits and reports his progress to the clinic. From this data the clinic is able to keep in touch with the patient and to judge more accurately when he should return to the clinic for observation and examination. At his next visit he will receive a complete examination and whatever laboratory procedures appear to be indicated. The patient who has been rehabilitated at home, is frequently visited by the health nurse who reports his progress to the clinic, and when patient's condition will warrant a visit to the clinic, she is instructed to transport him here for further observation and examination. The frequency of these visits depend on the condition of the patient and the form of therapy. If laboratory procedures may be had in home counties, if the follow-up for salicylates and sulfa may be done there, it lessens the necessity for transporting the patient to this clinic, where such laboratory work is done. We have always contended that it is very desirable to check salicylate levels and blood findings on active patients, and sulfa levels and blood findings on those patients who are in the inactive phase and who are taking sulfadiazine as a prophylactic procedure. As you know both of these drugs have a tendency to depress the granulocytic element in the blood.

In treating the active cases we have tried some of the other drugs such as aspirin and pabalate, which appear to be of some value, but not proven to be as efficient as sodium salicylate. Cortisone has not been as satisfactory in our clinic as has been reported elsewhere. It often produces a state of well-being without influencing the course of this disease. However, we have seen some rather pleasing effects from the use of this agent, particularly if administered in large doses during the first episode of this disease. Although, if the patient has severe cardiac damage, one should beware of the possibility of the retention of sodium chloride which may increase the blood volume and produce evidence of pulmonary edema and cardiac failure. If the patient is given a salt poor diet, there is less likelihood of the development of this cardiac complication. Sometimes cortisone appears to be of value in acute exacerbations of the old cases of Rheumatic Fever which has apparently become somewhat resistant to sodium salicylate. In these types of cases the combined use appears to be of more value than either one alone.

Penicillin is of decided value in treating sore throats where the hemolytic streptococcus is probably the predominating organism. Also we have been led to believe that as a prophylactic procedure it has lessened the necessity for laboratory work and does not require the frequent observation by the follow-up nurse. Although, some patients in the hospital on this prophylactic measure have not been benefited because the homolytic streptococcus in their throats was resistant to penicillin.

It may be of some interest to mention our experience with sulfadiazine as a prophylactic procedure. When it is given in sufficient dosage to raise the concentration in the blood to 2 to 3 milligrams % and maintain this level, the Rheumatic Fever patients will relapse less frequently, and often they will be able to attend school and participate in the chores thereof. On account of the marked cardiac damage which some of these patients have, we have maintained them on this type of prophylactic regime for many months and even years without demonstrable continue the sulfadiazine because of its depressive damage. However, it may become necessary to discontinue the sulfadiazine because of its depressive effect on blood formation.

Vitamins in general and particularly ascorbic acid make up a large part of our therapeutic storehouse, for most of our patients exist on deficient diets which are void of these essential ingredients. Of course, where the diet is adequate in the essential food elements there is very little benefit to be derived from the administration of these accessory food factors.

It may be of some interest to discuss with you our clinic procedure in following these Rheumatic Fever patients. The active bed patients are seen every four (4) to six (6) weeks; convalescent six (6) weeks to three (3) months; inactive with marked heart damage, three (3) to six (6) months; inactive with minimal damage, six (6) to twelve (12) months; and questionable cases as indicated. However, patients are instructed to contact the clinic should any unfavorable disturbances occur. When seen in the clinic, the patient is given a complete physical examination and indicated laboratory procedures are done, progress and treatment reviewed and evaluated so that the nurse and attendant may be instructed concerning his future management. During these intervals and when we are anxious about the patient's progress, we send an elaborate follow-up questionnaire to the visiting nurse, who forwards the desired information. Then if it appears necessary, the visiting nurse is contacted by telephone for further consultation. Also in cases of emergency the visiting nurse is instructed to contact the clinic by telephone. In this manner, we have developed a fairly satisfactory follow-up system.

A qualified and efficient social worker fits well into our clinical organization and is of considerable value, for, by her efforts, patients and parents are taught how to adjust themselves so that they will find less difficulty in fitting into a new pattern. Also she renders many other services which are essential to the welfare of the clinic.

Since this clinic must function in a diagnostic capacity and since there are many ailing children who have not had the advantage of a complete work-up, and since health departments have learned that this clinic may help them in solving some of their sick problems, we often see a variety of ailing children. This group may include rheumatoid arthritis, sickle

cell disease, congenital anomalies of the heart, asthmatics, orthopedic problems, children infected with intestinal parasites, psychosomatic syndromes, malignancies and etc. Fortunately for them, there are co-ordinating clinics; heart, cancer, mental hygiene, and orthopedic, where these patients may receive further examination and study so that the Rheumatic Fever Clinic will be able to more accurately catalog them for proper dispensation and treatment. It is very soothing and relaxing to share with other clinics some of your disturbing problems. The cooperation of these clinics furnish the means whereby these unfortunate patients are partially or completely rehabilitated and thereby better prepared to fit into a more useful pattern of society.

Would it interest you to know that seven hundred and twenty-five (725) patients have been seen in this clinic. That three hundred and fifty-one (351) are now on our active files. We have three hundred and seventy-four (374) in our inactive files. Many of those in the inactive files were not Rheumatics, some were non-cooperative, others moved out of this district, a small number died at home and three (3) died in Roper Hospital. A fair number of this group of patients are now being followed by their family physicians. The clinic has twenty-eight (28) active Rheumatic Fever patients now receiving treatment, thirteen (13) of these patients are confined to bed in their homes, ten (10) are being cared for at the Convalescent Home in Florence, and five (5) are bed patients at Roper Hospital, where the most serious cases are maintained. We are following thirty-five (35) ambulatory and inactive patients who are receiving sulfadiazine, and fifteen (15) who are taking penicillin as a prophylactic measure. During the past year, sixty-nine (69) acute and one hundred and fifty-seven (157) chronic cases were followed and treated. It is noted that all the acute cases were approximately equally divided between the two sexes, while the chronic cases were thirty-three (33) percent higher in females. The greatest incidence occurred in the group between five (5) and fourteen (14) years of age. The total number of patients seen during the past year is lower than the average because of insufficient funds to properly staff the County Units, who form a vital part of this organization.

This clinic will be holding each Thursday morning for the purpose of seeing new and old cases of Rheumatic Fever. We examine four (4) new and eight (8) or ten (10) old cases during the clinic hours. These cases are selected and appointments made in advance of expected clinic visits. If the patient and nurse are unable to attend, an alternate is substituted so that we may see as many patients as possible. Their condition, progress, problems, and treatment are discussed with the visiting nurse and attendants. Sometimes, we find that the patient is not making the anticipated progress. If we are unable to remove or overcome these difficulties, he is admitted to the hospital for further study and treatment

which may extend over several weeks, before he has sufficiently recuperated to further convalesce in his home surroundings.

Fellow practitioners, we beseech you to refer these unfortunate cases to us at an early date. Then we will have an excellent opportunity to rehabilitate and restore them to productive and useful citizens. But if you delay until this disease has wrought havoc with their minds and bodies, the golden opportunity for rehabilitation has been lost forever.

Submitted by Staff of the Rheumatic Fever Program:

M. W. Beach, M. D.—Pediatrician and Director

C. D. Conrad, M. D.—Assistant Pediatrician

J. A. Boone, M. D.—Cardiologist

C. G. Castles, M. D.—Teaching Fellow

Miss Mildred E. Blackwell, R. N.—Public Health Nursing Consultant

Miss June Jones—Clinic Clerk

CANCER

Edited by JOHN C. HAWK, JR., M.D., Charleston, S. C.

CARCINOID TUMORS OF THE GASTRO-INTESTINAL TRACT

HENRY W. MAYO, JR., M. D.

One of the most interesting lesions encountered by the gastro-intestinal surgeon is the carcinoid tumor. Until recently these tumors were thought to be quite rare, but they are being reported with increasing frequency and are probably more common than is generally supposed.

As the name "carcinoid" indicates, these lesions simulate carcinoma in that all layers of the intestinal wall may be involved by the growth, but the gross and microscopic characteristics of these lesions differ from carcinoma. Grossly, carcinoids tend to be small tumors of rubbery consistency which grow chiefly beneath the mucosa of the bowel, pushing the mucosa into the lumen as they enlarge; on cut section, they present a firm surface and a very characteristic yellowish coloration. Microscopically, these lesions are composed of densely packed masses of rather small cells with clear cytoplasm and without much pleomorphism, but some of the lesions may show gland formation. Carcinoids are believed to be derived from the Kulschitzky cells in the crypts of Lieberkühn. Formerly they were called argentaffinomas, because of their affinity for the silver stain, but Stout⁸ has shown that some of these lesions will not take the silver stain; these he believes to be derived from the same cells in the "preenterochrome" phase.

From a clinical point of view, for purposes of analogy, the carcinoids of the gastro-intestinal tract might be likened to the basal cell carcinomas of the skin. They grow very slowly and metastasize via the regional lymphatic routes, but apparently metastases occur long after the growth first appears. The life history of these lesions is so long that there are numerous reports⁵ of cases in which, despite the presence of distant metastases, removal of the primary lesion resulted in a symptom-free interval of many

years. Formerly, carcinoids were considered to be benign mimickers of malignancy, but in recent years, the pendulum of opinion has swung to the opposite pole, and the consensus of authorities recently reviewing the subject is that all carcinoid tumors are malignant.⁵

Carcinoid tumors have been reported to occur in the appendix, small bowel, colon and rectum, stomach, duodenum, gallbladder, and Meckel's diverticulum. The latter locations are so rarely the site of carcinoids as to be medical curiosities, but carcinoids of the appendix, small bowel, and large bowel are sufficiently common so that they may be encountered in the experience of every practitioner, and hence merit separate discussion.

Appendix—An appendix which is rather short and stubby, with a hard bulbous enlargement, usually of the distal end, may be suspected of harboring a carcinoid tumor. The cut surface of such an appendix may present the typical firm rubbery yellowish tissue, the growth of which has resulted in partial or complete obliteration of the lumen. According to Foot,¹ appendiceal carcinoid is found in 0.46% of all organs removed with a pre-operative diagnosis of appendicitis. While these tumors have the same invasive characteristics as carcinoid tumors elsewhere, metastases from appendiceal carcinoids are exceedingly rare. It is postulated that growth of the lesion results in blockage of the small appendiceal lumen, thus giving rise to symptoms of appendicitis; with the present consciousness of the importance of early removal of the infected appendix, few of these organs containing carcinoids will remain in the body sufficiently long to allow metastases to occur. Suffice it to say that simple appendectomy is a curative procedure in almost every case, and no further procedure should be contemplated unless there is definite evidence of metastases.

Small bowel—A recent review by Grimes and Bell² indicates that carcinoids of the small bowel are more common than is generally appreciated. These tumors may occur anywhere in the small bowel, but they

From the Department of Surgery and the Cancer Clinic, Medical College of South Carolina, and the Roper Hospital, Charleston, S. C.

seem to have a predilection for the terminal ileum. They grow slowly, produce little if any bleeding in the intestine, and metastasize slowly to the regional lymph nodes in the mesentery. Liver metastases, presumably blood borne, have also been reported, but are uncommon. In their early stages, because of their location, these tumors are quite difficult to diagnose. The patient may present a variety of vague abdominal complaints, of which cramping pain and nausea are the most common. Repeated barium enemas and upper gastro-intestinal X-rays, including small bowel series, may be negative, and the patient may for that reason be stigmatized as a psychoneurotic. Occasionally, when barium is forced through the ileo-cecal valve during the course of a barium enema, the lesion in the terminal ileum may be visualized. As the lesion grows, the direction of growth is usually intra-luminal, with an associated constriction of the diameter of the bowel, so that later in the course of the disease, the patient will present the typical symptoms, physical signs and X-ray findings of partial or complete small bowel obstruction. The picture of chronic progressive low small bowel obstruction, accompanied by anemia and weight loss, raises the possibility of the presence of carcinoid of the terminal ileum, although carcinoma, benign tumors such as fibroma, and inflammatory lesions such as regional enteritis must be considered in the differential diagnosis. As far as treatment is concerned, these lesions give the surgeon an unusual amount of satisfaction, because if he removes an adequate segment of bowel with the adjacent mesentery, the chances of cure are excellent, as compared with small bowel carcinoma, provided no distant metastases have occurred. Even in the presence of the latter, many years of asymptomatic life may follow resection of the primary lesion.

The writer has observed three such lesions in this institution in the past 26 months. Two of them were in patients who had been previously classified as psychoneurotics, because of bizarre abdominal symptoms and negative X-rays, but who finally presented themselves with the typical picture of chronic progressive small bowel obstruction, and at operation were found to have carcinoids of the terminal ileum with metastases limited to the adjacent mesenteric nodes. Wide resection and anastomosis was carried out in both cases, and these two patients have remained in good health, for one and two years respectively, without evidence of recurrence. A third patient was entirely asymptomatic with regard to the intestinal tract, but, at the time of a recent abdominal hysterectomy, she was found to have a small tumor of the terminal ileum, with a tremendous mass of mesenteric node metastases; the lesion was proved microscopically to be a carcinoid, and a wide resection encompassing the metastatic nodes in the mesentery, with end-to-end anastomosis, was accomplished. A characteristic finding in these small bowel lesions is that the tumors are quite small, and give the bowel a constricted appearance at the site of the tumor.

Colon and rectum—Carcinoids of the colon and rectum usually give rise to no symptoms, or, at the most, mild rectal bleeding, during the early phases of the disease. Later on, depending on their location, they may give rise to the symptoms of large bowel obstruction, including abdominal cramps, abdominal distention, and decrease in the caliber of the stool. Many of the smaller lesions are discovered by routine digital examinations of the rectum, barium enemas, or proctoscopies performed during the course of general physical check-ups. As has been emphasized so often, the occurrence of rectal bleeding demands these three examinations. These tumors of the large bowel seem to have less tendency to form annular obstructing lesions, and also less tendency to metastasize, as compared to the small bowel carcinoids. However, that metastases do occur is attested by the reports of Horn,³ and Pearson and Fitzgerald.⁶ They may be polypoid in nature, with a long pedicle, or they may be sessile. It is felt that local excision of a polypoid lesion is sufficient in the way of treatment, provided that the tumor does not involve the stalk of the polyp. The sessile lesions often may be cured by local removal, with a small margin of surrounding mucosa and submucosa, providing that there is no invasion of the muscularis, and providing there is no evidence of regional node metastasis. Abdomino-perineal resections have been done for small lesions of this sort,⁷ but it seems unjustifiable to submit a patient to such a deforming and radical procedure in view of the known^{4,9} uncommon occurrence of metastases. Of course, if metastases are evident, or if the tumor cannot be removed easily by local excision, then a definitive resection such as is done for carcinomas is indicated. It should be noted that carcinoids of the rectum may be confused with small cell carcinomas by an inexperienced pathologist, and the distinction is important, since it governs treatment. Two such lesions of the rectum have been observed in this institution, and reported elsewhere.⁴ These two patients have survived 22 and 32 months respectively after local excision, without proctoscopic or other evidence of recurrence.

In summary, carcinoids of the gastro-intestinal tract are not uncommon tumors which are of low-grade malignancy, growing slowly and metastasizing slowly. Appendectomy will be curative for the appendiceal carcinoid, and limited operative procedures will be sufficient for most cases of large bowel tumors of this type, but a more extensive resection will be necessary for small bowel carcinoids, because the incidence of metastases is higher in the latter. The prognosis for the treated patient in each instance is excellent.

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MINUTES OF COUNCIL MEETING MYRTLE BEACH, S. C. 5/12/52

Council was called to order by the Chairman, Dr. O. B. Mayer, at the Ocean Forest Hotel, Myrtle Beach, S. C., at 2:40 p. m. on May 12th. Others present were: Drs. Guess, Bozard, Thackston, McCants, Sease, Latimer, Price, Wyatt, Gressettee, Joe Cain, Jr., D. L. Smith, Weston, Jr., Heyward, and Mr. Meadors.

The minutes of the previous meeting were read and adopted as read.

The Secretary was then called upon to bring to the attention of Council such matters as needed its attention. The following matters were brought up: First, two cases of grievance, one from Charleston, and the other from Columbia. Both had been referred to their respective local societies, and action had been taken in Charleston, and action is under consideration by the Grievance Committee of the Columbia Medical Society. Second, information had been furnished for the President concerning the delegates, notices to the committee chairmen, and names of councilors, members for the Nurses Board of Examiners, and members of the Board of Medical Examiners, whose terms expire this year. Third, information about scholarships to the medical schools. Fourth, copies of the editorial from the A. M. A. titled *Pensions for Physicians*. Fifth, civil defense matters. Sixth, an invitation to join the National Society for Medical Research. Seventh, Honorary members and the latest on the membership and fellowship structure of the A. M. A. Eighth, credentials furnished for the delegates to the American Medical Association.

Dr. A. C. Bozard brought up the matter of Dr. Kelly, Sr. being barred from the Georgetown Hospital. The status of Dr. Armstrong of Georgetown has been changed from his former status of being paid by the Hospital for any work done there. Dr. Armstrong is in independent surgical practice, paying rent for offices in the hospital, presenting and collecting his own fees.

The following reports were presented: First, Editor of THE JOURNAL, Dr. Price reported a nice profit on THE JOURNAL. Second, in the absence of Dr. Stokes, Treasurer, Mr. Meadors read his report. Finances were reported in good condition. Chairman of Council, Dr. Mayer, was commended by Council for the manner in which he managed a financial emergency during the prolonged absence of the Treasurer last summer. Third was the report of the Chairman of Council, Dr. O. B. Mayer. Dr. Guess moved, seconded by Dr. Bozard, that the Chairman read his report with the statement that copies of the Treasurer's report be distributed to the House of Delegates. Fourth, the Business Manager and Director of Public Relations, Mr. Meadors, gave his report. Fifth, the Secretary was asked to read the report that he had prepared to read to the House of Delegates, which he did. No comments. The Vice-President, Dr. J. B. Latimer, had no report; nor did Dr. L. P. Thackston, President-Elect. Sixth, the President, Dr. J. D. Guess, read his report, consisting largely of matters pertaining to the Blue Shield and the Blue Cross.

Due to the expiration of two terms, a death, and

two resignations, there were five vacancies on the Board of the Blue Shield and the Blue Cross. For these vacancies, Council nominated Dr. George Johnson, Dr. A. C. Bozard, Mr. W. W. Lawrence, Dr. J. P. Ashmore, and Mr. Graham Seagers. These were to be presented to the Corporation for election.

Dr. Wells Brabham was nominated by Dr. Sease, seconded by Dr. Cain, to fill a vacancy on the Executive Committee of the South Carolina Medical Care Plan.

A committee for news releases to the press was appointed consisting of the Editor of THE JOURNAL, the Business Manager, and the Secretary.

Dr. Price explained some of the changes in the Constitution and By-Laws. Dr. Cain moved, seconded by Dr. Weston, that the insurance men be heard at some future meeting, for the explanation of the group insurance plan for disability, life insurance, and retirement insurance.

Dr. Weston moved, seconded by Dr. Mayer, that Dr. Harry S. Mustard's name be presented to the House of Delegates for election to the S. C. M. A. as an Honorary Fellow, in appreciation for most valuable and timely services rendered, concerning the State Board of Health.

Dr. Wyatt moved, seconded by Dr. Smith, that gold button awards for fifty years practice in the State, be continued. This was passed.

Dr. Guess then invited Council and their wives to a cocktail party in his room immediately following adjournment.

Council was recessed at 5:00 p. m. to reconvene at 9:00 a. m. on May 13th.

Tuesday, 9:30 a. m., May 13th

The meeting was called to order by the Chairman, Dr. Mayer. The meeting was for the purpose of hearing the report from the Woman's Auxilliary. There were 14 members of Council present.

The Secretary of the Association was appointed to escort the President of the Woman's Auxilliary, Mrs. Kirby Shealy of Columbia, into the meeting; and, any other member of the Auxilliary wishing to attend. Mrs. Shealy gave her report on the activities of the Auxilliary during the year. Mrs. Whetsell of Orangeburg, President-Elect, gave a short report on the planned activities for the coming year. Mrs. D. A. Wilson of Greenville, Treasurer of the Auxilliary, gave a detailed financial report, and furnished a copy for Council.

Dr. Weston, Jr., asked that the efforts of the Auxilliary be used to help get parent-teacher's associations over the state to oppose socialized medicine influences in the schools. Dr. J. D. Guess, President, and Dr. Thackston, President-Elect, endorsed this heartily. Dr. Weston then put this in the form of a motion, seconded by Dr. Wyatt. This was passed.

Recessed at 9:50 a. m. to meet again at 9:00 a. m., May 14th.

Wednesday, 9:00 a. m., May 14th

The meeting was called to order on May 14th, 9:00 a. m. by the Chairman. A quorum was present. The main purpose was to receive two nominations by the Councilors from each district for members of the

(Continued on Page 172)

The Journal of the South Carolina Medical Association

EDITOR: Julian P. Price

Florence, S. C.

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OUR NEW OFFICERS

The Journal wishes to extend its congratulations to those men who have been selected as our leaders for the coming year. It is our sincere belief that they have the ability and determination needed to carry on our Association's work successfully.

Dr. Lawrence Thackston brings to the presidency a wealth of experience—veteran of World War I and II, he has served as president of his district society, as a member of council for a decade, and on special committees for the Association. He is a urologist and a leader in scientific medicine in his section of the section. A man of courage, who does not hesitate to express himself, but a man who is also fairminded, willing to hear the other man's point of view—he has the capacity for leading others.

Chosen as President-elect is Dr. C. R. F. Baker of Sumter. Prominent surgeon, past-president of his county and district society, councilor from his district for nine years, Dr. Baker is extremely popular—as evidenced by his unanimous election — and well qualified to assume the duties of his new office.

Dr. George D. Johnson of Spartanburg is the new Vice-president. Well known pediatrician, leader in his own district, active member of the S. C. Medical Service Plan Board of Directors, Dr. Johnson brings to the Association and Council a viewpoint that should prove healthy.

Our Secretary is Dr. Robert Wilson, Jr. of Charleston. A man of many activities and interests—internist, teacher, civic leader, member of city council, secretary of the Medical Society of S. C. (i.e. Charleston county medical society) for many years—Dr. Wilson is well equipped for his new office.

We expect great things from these new leaders of ours and we beg for them the support and cooperation of all the members of the Association.

S. C. GRIEVANCE COMMITTEE

At long last, our Association has established a Grievance Committee. The final action was taken by our House of Delegates at its recent annual session

when it adopted the broad principles under which the committee will operate and elected the members who will serve.

The committee will be composed of nine men, one from each medical district of the state. These men will select their own chairman. It will be their function to receive any complaints against the professional or ethical work of any member of the Association and to attempt to work out an amicable adjustment. Complaints must be in writing and both parties to the misunderstanding will be asked to present their case. The first attempt to settle the difficulty will be made by a small committee of three, and if this cannot be done the matter will be referred to the entire committee. Should the committee decide that specific action ought to be taken against a physician for unethical conduct, the matter will be referred to the Council for final action.

We are delighted that the plunge has been taken and that the committee will soon be functioning. It will not only help us to "clean our own house" of that very small number who are a discredit to the profession, but it will show the public that we are not unmindful of our own weaknesses and mistakes and are anxious to correct them.

1952 ANNUAL MEETING

The annual meeting of 1952 is now history, but as we think back upon its proceedings there are certain memories that stand out in sharp relief.

Dr. J. D. Guess, our retiring president, made an excellent presiding officer and handled the business with fairness and dispatch. Having sessions of the House of Delegates on successive days allowed more time for discussion and deliberation. The reference committees functioned well and although the work was new to the various chairmen, they performed their tasks with efficiency. The question of having a Speaker of the House evoked quite a bit of argument—and this is healthy. The invitation to meet next

year in Columbia was accepted but there are still those who think that Myrtle Beach should be the perennial site for the meeting. The scientific papers were of high calibre. The banquet was well attended, was handled well, and Dr. McSween's address was well received.

All in all, it was a good ending for those officers who went out of office and a fine beginning for those who now take over the reins.

SUPREME COURT RULES IN FAVOR OF OREGON MEDICAL SOCIETY

The United States Supreme Court in a seven to one decision April 28, dismissed an appeal of the government against the Oregon State Medical Society, eight county medical societies, Oregon Physicians Service, and several physicians who are or were officials of these organizations. Previously a U. S. District Court had ruled against the government's antitrust violation charge and a direct appeal had been taken to the U. S. Supreme Court.

The controversy in Oregon began in 1936 when the medical society opposed contract practice of medicine sponsored by private firms and commercial insurance companies. At that time the medical Society charged that medical treatment and service was dependent upon company approval and in some cases the advice of physicians was disregarded. The medical society raised the ethical objection that third parties were entering the doctor-patient relationship. The medical society in an effort to bring about reform of prepaid medical service within the state, decided in 1941 to render itself such service on a nonprofit basis. After seven years of successful operation of the society plan the government brought suit charging the society with monopolizing the business of providing prepaid medical care within the state.

The Supreme Court said at one point, "Objections of the organized medical profession to contract practice are both monetary and ethical. Such practice diverts patients from independent practitioners to contract doctors. It tends to standardize fees. The ethical objection has been that intervention by employer or insurance company makes a tripartite matter of the doctor-patient relation. Since the contract doctor owes his employment and looks for his pay to the employer or the insurance company rather than to the patient, he serves two masters with conflicting interests. In many cases companies assumed liability for medical or surgical service only if they approved the treatment in advance. There was evidence of instances where promptly needed treatment was delayed while obtaining company approval, and where a lay insurance official disapproved treatment advised by a doctor."

And at another point the Court said, "Since no concerted refusal to deal with private health associations has been proved, we need not decide whether it would

violate the antitrust laws. We might observe in passing, however, that there are ethical considerations where the historic direct relationship between patient and physician is involved which are quite different than the usual considerations prevailing in ordinary commercial matters. This Court has recognized that forms of competition usual in the business world may be demoralizing to the ethical standards of a profession."

Mr. Justice Clark, who was formerly the Attorney General of the United States, took no part in the consideration or decision of the case, probably for the reason that the government suit was commenced during the time while he was serving as Attorney General.

Mr. Justice Black, the lone dissenter, did not write a minority opinion. The majority opinion was written by Mr. Justice Jackson.

IN RETROSPECT

The 1952 annual meeting of the South Carolina Medical Association ended in a brilliant climax, with the loveliest banquet we have had in many years.

Plans for this meeting began shortly after the meeting last year, and many people contributed to its success. The banquet hall was beautifully decorated by Mrs. Shealy's committee on arrangements, headed by Mrs. Lippert. These ladies worked in excellent taste and with enthusiasm. Mrs. George C. Brown, Jr. graciously played selections on the piano while the group was being seated. Dr. McSween, the after-dinner speaker, was in fine fettle, and he held the interest of his audience throughout his talk in which his thesis, how to live successfully, was generously interspersed with humorous stories of doctors and the lives they lead.

The scientific program was well attended and proved to be interesting and instructive. Dr. John Rainey and his committee had planned well. The papers were well prepared, well presented, and the speakers contained themselves within the time limits set for them.

Dr. L. C. Reid of New York furnished the highlight of the program in two addresses dealing with the subject of salt and water balance.

A careful reading of the minutes of the meeting of the House of Delegates will reveal several interesting things. The special committee on revision of the Constitution and By-laws had done their task in a comprehensive manner. The committee had provided for the contingency of adoption by the House of the proposed amendment which would have created a speaker of the House. (The proposal received considerable opposition and failed to receive a two-thirds favorable vote and so was lost.) It, also as a basis for discussion next year after it has lain on the table for one year, included in its report a proposed constitutional amendment limiting the tenure of

membership of past presidents in the House to five years. There has developed a misunderstanding on the part of many regarding this inclusion. The special committee did not endorse or recommend the adoption of this amendment. They had no such power. However, notice had been served that one or more resolutions bearing on tenure of membership of past presidents in the House would be introduced. The inclusion of such a provision in its report provided an orderly way for the reception of such a motion and its referral to the table, and for its consideration next year. At that time, the whole proposal may be killed, adopted as made, or amended in any way that the House desires. Proposed changes in the By-laws were presented which will remove denial of membership in the Association to negro members of constituent county societies. This was in line with the report of a special committee which had studied the petition of negro doctors for admission as members of the Association.

The committee searched the minutes and incorporated in their report all amendments to Constitution and By-laws which had been made since 1944. The whole matter of committees was revised in the report of the committee. Several standing committees were dropped, because of changed conditions, and a system of legislation by reference committees was recommended. This report of the special committee was referred to a reference committee, with Dr. Kenneth M. Lynch chairman. Several interested delegates attended the hearing by Dr. Lynch's committee, and a new report was prepared, which in the main paralleled the report of Dr. Price's special committee. Dr. Lynch moved the adoption of his report as a whole. The chair reminded the delegates that this motion to adopt as a whole could be passed, killed or amended, and if amended, it could be by deletion of or addition to any of its proposals. Further, if the resolution to adopt as a whole was killed, the report could be taken up item by item for disposal. The resolution to adopt as a whole carried easily.

Other matters of business were largely routine and were not controversial and consisted mostly of adoption of committee reports.

Dr. Dick Baker was the only nominee for president-elect, and he was elected by acclamation. Dr. Barney Heyward would not allow his name to go up for reelection as secretary, and he nominated Dr. Robert Wilson, Jr. for that position. Dr. Wilson was unanimously elected.

The House voted to go to Columbia for next year's meeting—the question being decided by a majority of one vote. The chair hoped for a tie, so that he could cast the deciding vote for Myrtle Beach. The fact that conditions, facilities and courtesies had been so greatly improved over those of the last several years, and the fact that the Association and its guests occupy the entire hotel during its stay, and

the recreational facilities afforded by a beach resort, would have determined his vote.

The success of the meeting in all of its phases was brought about by the capable and enthusiastic cooperation of many individuals, and no one man or group should receive all of the credit for it. May I take this opportunity to express my sincere thanks to these numerous individuals? During the year, I was extended many courtesies and was pledged unsolicited cooperation and support by many individuals. I am humbly grateful.

It is my opinion that the Association has entered a new era of harmony, cooperation, and usefulness to the profession and through it, to the people of our state. Under the able leadership of Dr. Thackston and with the same kind of support given me, it cannot be otherwise.

J. Decherd Guess, M. D.

DOCTOR, YOUR STATISTICS ARE SHOWING

The AMA's Membership Department has gone mechanical. To facilitate the processing of membership records, more than 350,000 IBM cards—approximately two and one-third cards per AMA member—have been added to the Department's files. These cards contain statistics such as the physician's dues payment, specialty, medical school, date of graduation, address and birth date. This new system will make possible a record of membership which can be readily tabulated and processed.

GUIDED TOURS OF AMA HEADQUARTERS

If you are planning to visit Chicago this year, plan to take advantage of the new guided tour service at AMA headquarters. Here's a chance to see your Association firsthand. This service will be available during the AMA annual session, and all attending the convention are invited to visit 535 North Dearborn Street. Guided tours will leave the AMA front lobby every hour on the hour from 9 a. m. to 4 p. m., June 9 to 13. This tour program is to be a permanent AMA service.

NEW PHYSICAL LABORATORY

Latest addition to AMA headquarters in Chicago is the new physical laboratory which was opened last month for testing of devices submitted to the Council on Physical Medicine and Rehabilitation. Dr. Frederic T. Jung, director of the laboratory, says that the majority of the laboratory's work is concentrated on testing actual mechanics of new devices submitted by manufacturers to the Council. This supplements the clinical testing which will continue to be done by practicing physicians who cooperate with the Council in this way. The results of physical and clinical testing are referred to the Council for evaluation and approval.

NEW PAMPHLET ON COST OF SICKNESS

To create a better understanding of one of the major causes of patient-doctor misunderstanding—the cost of illness—a new pamphlet has been designed for public distribution. Entitled “Your Money’s Worth in Health,” the booklet stresses the various aspects of patients’ medical bills and the cost of illness in relation to the national income. The pamphlet shows graphically that the cost of illness has not risen as much or as rapidly as other consumer goods. This illustrated eight-page pamphlet soon will be made available to AMA members and medical societies for distribution to the general public.

STUDENT AMA GROWS

Three new chapters have applied for membership in the Student American Medical Association, bringing the total number of active and provisional chapters to 47. The new groups are located at Western Reserve University, the University of Southern California and the State University of New York at Brooklyn. Organizational plans are being developed at other schools, including Northwestern, Vanderbilt, Tennessee, Cincinnati, New York Medical College, Iowa, North and South Carolina, Minnesota and West Virginia. Recently, the SAMA’s executive council voted to change the annual meeting date from December to June, effective with the 1953 meeting.

DEATHS

ALLEN HUGGINS JOHNSON

Dr. Allen H. Johnson, 41, died suddenly May 13 of a heart attack which occurred while he was working in the hospital.

A native of Georgetown county, Dr. Johnson received his education at the University of S. C. and the Medical College of S. C. (Class 1934). Following a surgical internship and residency at Columbia Hospital, he practiced surgery at the James L. Martin Hospital in Mullins for two years. He then moved to Hemingway where he opened the Johnson Memorial Hospital, of which he was owner and chief surgeon. Over the years he built up a large following and carried on an extensive practice.

In addition to his professional work, Dr. Johnson was engaged in many community and business projects. He was past president of the Hemingway Civitan Club, a director of the Anderson State Bank of Hemingway, a member of the Hemingway Methodist Church, and a past-president of the Williamsburg County Medical Society.

Dr. Johnson is survived by his wife, the former Miss Mae Burgess, and two sons.

JOHN W. WICKLIFFE

Dr. John W. Wickliffe, 87, died recently at his home in West Union. He had spent several years in retirement after some sixty years of general practice.

A full column editorial in the *Walhalla Keowee Courier* testifies to the esteem in which Dr. Wickliffe was held by those who knew him—and the number was great. A few sentences from that editorial tell their own story:

“A colorful and humanitarian portion of Oconee county’s past went into history last week with the passing of a widely-beloved man who did more than his share to make that past a dedicated one. . . . Hardly a family in the upper portion of Oconee—and in many cases the lower section as well—was not helped along the road of life at some time by the good doctor. . . . Even today there are hundreds of people who can tell you first-hand of anxious nights when the stately little doctor saved a life by performing operations on the kitchen table of some farm house while an anxious father, mother or husband held the lantern to furnish him light for seeing.

“What we personally always felt was a fitting anecdote in the life of Dr. Wickliffe was the fact that his grandchildren called him by the loving nickname of ‘Daddy Luke.’ The phrase referred, of course to Luke, the good physician of Biblical renown.”

OSCAR PATRICK WISE

Dr. Oscar P. Wise, 74, general practitioner of Saluda, died at the Columbia Hospital on April 24.

A native of Saluda county, Dr. Wise received his education at Newberry College and Tulane Medical School (Class 1904). After receiving his medical degree he returned to his native community and entered general practice. At first with horse and buggy, then with car he ministered to patients of the entire county. Ever cheerful, he carried a smile as well as medical care to those who sought his services. One of his favorite jests was that 90 percent of patients would get well if the doctor called and 95 percent would get well if he did not call.

Dr. Wise was a loyal member of his profession. He was a regular attendant upon medical meetings. He served with distinction as a medical officer in World War I and as a medical examiner in World War II. A great lover of sports, both afield and on the athletic grounds, he had recently completed a fishpond. He was a life member of the Mt. Pleasant Lutheran Church.

Dr. Wise is survived by his son, Dr. Allen C. Wise of Saluda.

NEWS ITEMS

Dr. James Albergotti of Orangeburg has been elected president of the Eighth District Medical Society. Dr. A. B. Preacher of Allendale, was named Vice President, and Dr. Hyman Marcus of Orangeburg was made Secretary-Treasurer.

Dr. J. B. Berry, Jr. is now located in Marion as an associate of Dr. E. M. Dibble.

Dr. T. K. Fairey has resumed his practice in Johnston in order to relieve the shortage of physicians caused when Dr. Zack Gramling moved to Orangeburg. Dr. Wells Riley is expected to begin practicing at Johnston sometime in July.

Dr. Richard Goode Christopher of Landrum celebrated his eighty-ninth birthday recently. Dr. Christopher practiced medicine until his retirement several years ago.

Dr. William H. Prioleau of Charleston has been elected President of the Association of Surgeons of the Southern Railway System.

Dr. Luis Fernandez, Jr. has opened offices for the practice of medicine in Aiken.

Dr. John Boone of Charleston was re-elected President of the South Carolina Heart Association, and Dr. A. Izard Josey of Columbia was named Vice President.

Dr. G. R. Wilder of Bishopville, was recently elected President of the newly organized Lee County Medical Society. Dr. Robert Hicks was elected Vice President and Dr. Harvey McLure, Secretary-Treasurer.

Dr. Kenneth Lawrence of Florence attended the meeting in Southern Pines of the North and South Carolina Obstetrical and Gynecological Society.

Dr. Z. W. Gramling, who has been practicing in Johnston for the past several years, has moved to Orangeburg where he will practice.

Dr. T. A. Pitts of Columbia, has been selected as the South Carolinian who made the most distinguished contribution to the cancer control program during 1951. Dr. Pitts was presented a medal and citation at the spring meeting of the board of directors of the South Carolina Division of the American Cancer Society held in Columbia.

Dr. Charles B. Hanna has announced his association with Dr. Walter D. Hastings, Jr. in the practice of general surgery at Spartanburg.

DOCTOR WANTED

The State Training School at Clinton invites any good doctor, qualified to practice in South Carolina, to communicate with its Superintendent with reference to associating with the institution for permanent service. Residence and other perquisites offered, with reasonable salary as a beginning, and promotion after a relatively short service.

LOST

Lady from Charleston lost star shaped lady's pin at recent meeting at Ocean Forest Hotel. Had sentimental value.

If anyone knows anything of this pin, please notify Editor.

THE TEN POINT PROGRAM

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

PROPOSAL FOR SOCIALIZED MEDICINE DEFEATED

What undoubtedly will prove to have been the closest brush during the life of the present Congress, with the advocates of national compulsory health insurance, occurred on Monday, May 19th, when the House failed to pass by the necessary majority of two-thirds, H. R. 7800, denominated "Social Security Amendments of 1952."

The account of the origin and efforts by its sponsors to rush the measure through the Congress, throws a new and revealing light upon the extent to which the Administration supporters are willing to go in their effort to expand the field of socialistic activities of our Government, and especially to adopt a national system of socialized medicine.

H. R. 7800, on its face, appeared innocent enough. In fact, it would have provided changes in the existing Social Security statutes which seemed generally to be conceded as desirable, and which undoubtedly would have had the approval of the majority of the members of both Houses of Congress. Whatever may be the basic thinking of any citizen of the United States with respect to the wisdom of a system of social security and old-age and survivors' insurance, that system is already here and may as well be accepted by everyone. Since 1935, when it was originated in the United States, it has grown immensely and has

become an integral part of our concept of government. There is, in short, no prospect whatever that it will ever be abolished as long as the financial structure of the United States is able to support it, and, of course, its bitterest opponents would hardly wish the country to reach such an economic state that it would be unable to do so.

Given, therefore, the system of social security, it is natural that the members of Congress and the voters will expect it to be kept intact and to be expanded and improved at intervals. It is not surprising then, to find that many members of Congress would have favored a number of the provisions for expansion of benefits contained in the 1952 version of the amendments to the Social Security Law, and included in H. R. 7800.

According to the Bill's title, its purpose was "To amend title II of the Social Security Act to increase old-age and survivors insurance benefits, to preserve insurance rights of permanently and totally disabled individuals, and to increase the amount of earnings permitted without loss of benefits, and for other purposes."

The joker, the portion which would have meant a huge stride toward the goal of socialized medicine in the United States, was inserted in Section 3, without benefits of notice to the unwary and unsuspecting Congressman. It seems to have been generally con-

ceded after the vote, that the provisions of this Section, on which the issue actually was fought out, were responsible for the Bill's defeat. Fortunately, its full implications were recognized in time and they were brought to the attention of the members of the House with sufficient force and clarity to insure that result.

Section 3, which contained the dynamite, was headed "Preservation of insurance rights of permanently and totally disabled." After numerous paragraphs of definition of the terms "quarter of coverage" and similar verbiage so common to all of the social security statutes, subparagraph (c) would have included a new section relating to "Examination of Disabled Individuals."

EXAMINATION OF DISABLED INDIVIDUALS SECTION 220—

The Administrator shall provide for such examination of individuals as he determines to be necessary to carry out the provisions of this title relating to disability and periods of disability. Examinations authorized by the Administrator may be performed in existing facilities of the Federal Government if readily available. Examinations authorized by the Administrator may also be performed by private physicians, or by public or private agencies or institutions, designated by the Administrator for the performance of such examinations; and the cost of such examinations shall be paid for by the Administrator, in accordance with agreements made by him, either directly or through appropriate Federal or State agencies. In the case of any individual undergoing such an examination, he may be paid his necessary travel expenses (including subsistence expenses incidental thereto) or allowances in lieu thereof. Payments authorized by this section may be made in advance of or as reimbursement for the performance of services or the incurring of obligations or expenses, and may be made prior to any action thereon by the General Accounting Office.

With some eight out of ten people in the United States covered by the provisions of the Social Security statutes, the number of examinations which might be required in the years to come cannot be estimated, but the extent to which this provision would have been used can well be imagined.

To say nothing of the number, extent and frequency of such examinations, the authority thus attempted to be given to the Federal Security Administrator is directly in line with the proposals which have been made to the same effect in the several bills heretofore introduced providing for compulsory health insurance.

This far-reaching expansion of the social security system, an effort, in the words of one of the Congressmen who participated in the debate, to "sneak socialized medicine in through the back door," well-hidden within the deep confines of the bill providing for the extensive social security amendments, was introduced in the House and referred to the Ways and Means

Committee on May 12th. It was reported out of the Committee on May 16th, and "brought to the House floor for passage under a virtual gag rule on May 19th. Thus, a total of only four days elapsed from the time the bill was introduced until it was reported out of Committee, and only three days elapsed until it was brought up for final consideration."

The extent to which the fate of the bill turned on the issue of socialized medicine and the unwarranted authority provided for the Federal Security Administrator, is indicated in the following extracts from the statements of several members of the House in the course of the brief debate:

MIR. REED OF NEW YORK:

One of the things we object to, of course, is the fact that we have had no opportunity to be heard. We were called into executive session, and this bill was forced out over our earnest request that in all fairness we have a hearing on the bill. The other objection we have to the bill is the fact that it is opening the door to socialized medicine. I do not care who takes the floor and tries to sidestep that issue—it is here. So when you come to vote on this bill, you can just figure that if you vote for it under this suspension, which you cannot amend and where you have no opportunity to offer a motion to recommit, then you are voting for socialized medicine. It is a very clever device to mislead the House. They have baited the trap very well, with certain benefits, which, of course, I say we are not objecting to; we just do not like this type of socialized-medicine legislation, nor this way of bringing something in here at a time when the people who are opposed to the bill have no opportunity to wire in because there is a Western Union strike. The opponents only heard of it a few hours ago. They have tried to get their telegrams in. Many of you have had them delivered to you personally, and some have come in by special delivery letters. Many of them have to use the long-distance telephone, and still they cannot get their objections across as to socialized medicine.

The great issue presented by H. R. 7800 is whether we in the legislative branch of the Government are now to surrender our prerogatives and our duty under the Constitution to the Federal Security Agency, headed by Mr. Oscar Ewing. The question is just that simple.

DR. JUDD OF MINNESOTA:

It has been said here today that the opposition to this bill just came up in the last few hours. How could it have come up earlier? I see that the bill was not introduced until May 12, and it always takes time for bills to be discussed in committee, especially bills of the length and scope of this one. But it was reported out on May 16, only last Friday. How could the American people or even Members of Congress examine it, come to considered conclusions, and

Clinical Results* with Banthine®

(Brand of Methantheline Bromide)

22 Published Reports Covering Treatment of 1443 Peptic Ulcer Patients with Banthine

Comprising the reports published in the literature to date which give specific facts and figures of the results of treatment

AUTHORS	No. of Patients	Chronic, Resistant to Other Therapy	TYPES OF ULCERS				RELIEF OF SYMPTOMS (Chiefly Pain)				Surgery or Complications ¹	Side Effects Requiring Discontinuance of Drug ²	EVIDENCE OF HEALING			
			Duodenal	Jejunal	Stomal	Gastric	Good	Fair	Poor	No Report			Complete	Moderate	None	No Report
Grimson, Lyons, Reeves	100	100	93	7			80	11	4		5		47		19	29
Friedman	15	15	14			1	5		4	6 ³			2			13
Bechgaard, Nielsen, Bang, Grønlund, Tobassen	26	26	21			5	16	4	6				8	6	12	
McHardy, Browne, Edwards, Marek, Ward	162		162				136	12	11		3	1	14	9	7	129
Segal, Friedman, Watson	34	34	34 ⁴				14	13			7	2	5		8	14
Brown, Collins	117	99	117				97	7	8		5	8	55	9	8	40
Asher	77		65		7	5	52	9	16			16		9	21	47
Rodríguez de la Vega, Reyes Diaz	5	4	5				4		1					3	2	
Winkelstein	116	116	102	8		6	102		14				53		18	45
Hall, Hornisher, Weeks	18	18	18				11		1	6 ³			18			
Mayer, Meili	38	38	24			14 ⁵	27	7	4 ¹				10	2	5	21
Meyer, Jarman	25	18	25				21		4							25
Poth, Fromm	37	37	37				33	3	1				33	3	1	
Plummer, Burke, Williams	41	41	41				36		5				38		3	
McDonough, O'Neil	104	100	104				63	10	31			11	4		11	89
Broders	60	60	58		1	1	35	19	6				10	1	49 ⁴	
Legerton, Texter, Ruffin	11		11				11									11
Holoubek, Holoubek, Langford	76	69	76				35	27	10		4	10	26		10	36
Ogborn	42		39	2		1	42 ⁵									42
Shaiken	48	48	48				33	10	3		2		33	10	3	
Johnston	145	145	145				143		2			2	143		2	
Rossett, Knox, Stephenson	146		141			5	146					4 ¹⁰	53			93
TOTALS	1443	968	1380	17	8	38	1142	132	131	12	26	54	552	52	179	634
PERCENTAGES		67.8 ⁴	95.6	1.2	0.6	2.6	81.3	9.4	9.3			3.7	70.5	6.6	22.9	

1. Not included in tabulations.

2. Included in "Relief of Symptoms" as "Poor" and in "Evidence of Healing" as "None."

3. Four had no symptoms when Banthine therapy was begun.

4. Of which seven were penetrative lesions and five partially obstructive.

5. No symptoms were present in four.

6. Two with symptoms only, no demonstrable ulcer.

7. Three were psychopathic patients and one had a ventricular ulcer of the lesser curvature.

8. Roentgen findings after treatment period of two weeks, forty-seven had duodenal deformity.

9. All returned to work within a week.

10. In these four, after relief of symptoms, Banthine was discontinued because of urinary retention.

During the past two years, more than 200 references to Banthine therapy in peptic ulcer and other parasympathotonic conditions have appeared in medical literature. Of these reports, 22 have presented specific facts and figures on the results of treatment in a total of 1,443 peptic ulcer patients, 67.8 per cent of whom were reported as chronic or resistant to other therapy. These results are tabulated above and show:

"Good" relief of symptoms was obtained in 81.3 per cent of the 1,405 patients on whom reports were available.

"Complete" evidence of healing was obtained in 70.5 per cent of the 883 patients on whom reports were available.

In all but 9.7 per cent, relief of pain was "good" or "fair." In all but 22.9 per cent, evidence of healing was "complete" or "moderate."

During treatment, 26 patients required surgery or developed complications other than ulcer which required discontinuance of the drug before results could be evaluated.

Of the remaining 1,417 patients, only 3.7 per cent experienced side effects sufficiently annoying to require discontinuance of the drug.



*Volume containing complete references with abstracts of 39 additional reports, will be furnished on request by

G. D. SEARLE & Co., P. O. Box 5110, Chicago 80, Illinois.

register their convictions except in the last few hours?

MR. SIMPSON OF PENNSYLVANIA:

Further, the bill now before you was undoubtedly written in every detail by Mr. Ewing and his assistant, Mr. Cohen, of the Federal Security Agency, and is a political bill. Probably no Member of the House objects to the increase of the primary awards on retirement, about \$5 a month, and Mr. Ewing seeks to use this bait to stampede through the House this legislation which also includes what appears to be Mr. Ewing's pet desire in life, namely, to socialize the practice of medicine in the United States.

Our citizens, in all walks of life, have repeatedly stated that they do not want socialized medicine here, which to them means they do not want any Federal agency telling them who their doctor shall be.

More than 60,000,000 of our workers are under social security. This bill would permit Mr. Ewing to set up a Federal bureau which could authorize by name, and otherwise limit, the doctors who would pass upon the physical condition of those who hope to retire under social security laws. This must not be allowed and the House should emphatically reject H. R. 7800 when we vote in a few minutes on suspension of rules.

MR. REES OF KANSAS:

Mr. Speaker, it is unfortunate this bill should be brought to the floor of the House under suspension that does not permit amendments of any kind and provides for a limit of only 40 minutes debate. The time is divided among only a half-dozen Members of the House.

A bill amending the Social Security Act is entitled to the fair consideration of the Members of the House and is entitled to be open for amendments on the floor. It is an important piece of legislation and should be carefully considered.

I am in favor of most of the provisions in this bill—those that provide for increases in benefit amounts. It should be observed that the increased benefits in this measure are small. It should also be observed that the liberalization provisions in this bill are smaller than they appear.

My principal objection to the bill is with regard to the provisions that border closely on socialized medicine. According to statements made on the floor, this bill opens the door for socialized medicine.

Of course, Members have not had a chance to examine or study this bill. As a matter of fact, copies were only made available over the weekend. The report, consisting of 50 pages, was filed only 3 days ago.

I do not want to be in the position of supporting a bill that either directly or indirectly provides for socialized medicine. The proper thing, as I see it,

with respect to such an important measure, is for the committee to reconsider this proposal and bring to the floor a bill that deals only with amendments to the Social Security Act. Members can then be permitted to vote on the bill after it has been thoroughly considered and subjected to amendment and debate.

All of the members of the House of Representatives from South Carolina were advised of the views of the profession on Saturday, May 17th, and requested to support an effort to defer action on the measure at least until public hearings could be held. We were pleased to note in the record of the roll call vote, the names of Representatives L. Mendel Rivers of the First District, John J. Riley of the Fifth, and John L. McMillan of the Sixth District, as voting against the motion to suspend the rules and pass the bill.

MINIMIZING TAXES*

Businessmen recognize the importance of adequate liquidity in the daily operation of a business enterprise. Liquid funds, for example, are essential to meet payrolls, to purchase inventory and supplies, to expand production under certain conditions, and to provide against unforeseen contingencies and emergencies which may arise. When business ventures are not successful, statistics indicate that many such failures are due largely to insufficient cash or inadequate working capital.

Unfortunately, many property owners fail to recognize that the settlement of an estate, insofar as liquidity is concerned, is somewhat like the operation of a business. Cash is needed for the obligations which death creates. Every estate, therefore, should be provided with adequate funds to facilitate its prompt and economical settlement. For the same reasons that a business may fail if its obligations cannot be met on schedule, the settlement of an estate may result in severe economic loss if the liquidity available is insufficient.

Death Creates Debts—Every estate, regardless of its size or composition, must be settled upon the death of the property owner. In the settlement of an estate, the executor is required to pay all of the decedent's just debts, taxes and the costs of settling the estate. If ready funds are not available, valuable assets may have to be sold—possibly under forced conditions or on an unfavorable market at a fraction of their real value.

Debts are Sometimes Accelerated—In certain instances, an individual's death will accelerate obligations which were not due during his lifetime. This happens, for example, in the case of demand promissory notes and money which may have been borrowed for business purposes on the strength of the decedent's reputation or his business experience.

*Extracts from a bulletin bearing this title issued by Connecticut Mutual Life Insurance Co.

and ability. If the estate is not in a position to repay these obligations conveniently, both the property interests and the future security of dependents may be jeopardized.

Taxes May Be a Formidable Item—Death taxes—both state and federal—often constitute one of the major debts which death creates. The federal estate tax, for instance, is determined by the fair market value of a person's estate, and it applies to all property which an individual leaves.* It is important to recognize that an individual's estate for federal tax purposes includes not only the value of all property which passes under his will but also life insurance which he owned or on which he paid the premiums directly or indirectly, and jointly owned property with the right of survivorship which was purchased with the decedent's funds.

In addition, property which a person did not own on the date of his death may sometimes be taxed in his estate for technical reasons. This is true in the case of gifts which were made in contemplation of death within three years of death, or other gifts over which the donor retained control until the time of his death.

The Effect of Inflation—Inflation is a complicating factor. The current upward spiral, for example, has been responsible for giving many persons an estate tax problem where none existed before and for intensifying the problems of others.

The federal estate tax is determined by the dollar value of property, measured in terms of dollars, has increased substantially even though the relative value of a specific asset may have remained unchanged. In some instances, this factor alone has increased the value of some small estates to the point where the federal estate tax must be considered, and it has created substantial liquidity shortages in other estates of moderate or larger size.

An Actual Example—Mr. A. died in October of 1950. His estate included a small office building which he had acquired in 1938 for \$45,000 and his residence which was built in 1939 at a cost of \$9,500. During the years between the acquisition of the property and Mr. A's death, real estate values had increased sharply in the community, and office space was at a premium. After a careful appraisal of the properties, Mr. A's executor decided that the lowest value which could be supported for federal tax purposes was \$18,000 on the residence and \$105,000 on the office building. Since Mr. A's estate was in a 30% tax bracket, this

increase in values, due largely to inflation, placed an unexpected and unplanned-for burden upon the estate.

The Use of Life Insurance—The accumulation of capital—and liquid capital in particular—has been quite difficult in recent years because of a combination of high income taxes and the high cost of living. Although inflation has resulted in most individuals receiving more earned income, the savings which are left over after taxes seldom accumulate fast enough to keep abreast of the additional cash demands which will be made at the time of death.

Liquidity When Needed—Life insurance is being used on an increasing scale by many property owners as a convenient and logical means of solving the liquidity problem in whole or in part, as well as providing the additional security needed for dependents in the present inflated economy. Such insurance makes it unnecessary to run the risk of living long enough to build up a sufficient backlog of liquid funds to meet higher death taxes or normal family requirements.

The payment of annual premium out of current savings, or out of capital in some cases, guarantees a fixed amount of cash at the time of death for the payment of debts, taxes and all other costs of settling an estate. In this way, valuable income-producing property may be retained and protected for the family regardless of when death may occur, and the estate may be planned with greater flexibility so as to meet unforeseen conditions which may arise in the future.

When Assets Are To Be Sold—There are many instances, however, when it is clearly to the family's advantage that certain business property or a business interest should be sold at the time of the owner's death. This is often the case where a sole proprietorship, a partnership interest or close corporation stock is involved and where it would not be wise to retain such business interest in the owner's estate for the benefit of the family. In this event, plans should be made during the owner's lifetime, when possible, for the sale of the asset at the time of his death. In such cases, business associates or key employees are usually the logical purchasers and are anxious to have the right and the ability to purchase the property involved.

In these cases, the need for adequate liquid funds to cover the purchase price in whole or in part is of vital importance to both the seller and the purchasers. The seller, for example, is interested in knowing that his estate will be paid in full and that his family will have the benefit of and security from the proceeds of the sale. The purchasers on the other hand, realize that they must be in a position to carry out their obligation to the owner's estate and that deferred payments of any substantial amount would not only be difficult to make but might not be acceptable to the executor.

Life Insurance, purchased and owned by the buyers

*The total of all the property left by an individual is known as the gross estate. From the gross estate, deductions are allowed for debts due by the decedent, funeral expenses and costs settling the estate. Furthermore, if the decedent's spouse survives, it may be that the estate will be entitled to a marital deduction. In addition to the deductions, an estate is entitled to a \$60,000 specific exemption under present law. After all of the deductions and the specific exemption have been subtracted, the remaining figure is called the net estate. The tax rates, which range from 3 percent to 77 percent, apply against the net estate.

on the seller's life, offers a very practical and economical solution for both parties. The purchaser guarantees for themselves a fixed and definite amount of capital through the simple medium of paying annual premiums. The seller has the satisfaction of knowing that his estate and family are protected and that the purchaser's financial program will produce necessary cash at the time it is required.

DEATH RATE LOWEST IN HISTORY

The nation made marked progress in its war against disease last year, registering the lowest death rate in United States history and making new inroads against the chief causes of death—cancer and heart disease.

The United States Public Health Service, in its annual report for the twelve months ended last July 1, said that the average life expectancy of Americans at birth now was sixty-eight years. It was only forty-seven years at the turn of the century.

Surgeon General Leonard A. Scheele warned, however, that chronic diseases, such as cancer and heart ailments were taking a greater toll, causing two-thirds of all deaths in 1950. He said this was partly because other diseases were being conquered and people were living longer. Cancer and heart disease are the chief foes of older persons. (N. Y. Times, April 1, 1952).

SECURITY LAW CAN BE ROUGH

Under an opinion of the general counsel of the Internal Revenue Bureau and the legal "lights" of the Social Security Administration, directors of corporations and trustees of savings banks, insurance com-

panies and for estates are considered "self-employed." Thus they are subject to the 2¼ per cent social security self-employed tax on such fees when they exceed \$400 a year. When the fees exceed \$600, Social Security payment to those over 65 are stopped. This ridiculous situation was first revealed by this reporter.

Here's an actual case of what happens under this legal opinion—

A director who is retired and over 65 serves on three boards, giving the concerns the benefit of his years of experience. His director's fees amount to \$2,750. Until this ruling by the Internal Revenue Bureau, he received \$816 in Social Security, for which he and his company had paid since the inception of this so-called pension law. He is now barred from this. He happens to be in the 50 per cent income tax bracket, so he pays a federal tax of approximately \$1,450. As a "self-employed" person he is subject to a 2¼ per cent tax of \$61.88. Being a New York State resident, he is clipped by Governor Dewey's income tax boys approximately \$220.

The "tax bite" on the \$2,750 totals \$1,731.88, leaving him net \$1,018.12. But he also loses his \$816 Social Security, which he paid for when he was working full time. So, the net result is \$202.12, which is hardly worth the bother.

The above figures assume his 100 percent attendance at director's meetings. If he attends less meetings and receives say \$2,000 in fees, he winds up a minus \$41. He loses his \$816 Social Security, his federal tax on \$2,000 is \$1,020, his self-employed Social Security tax is \$45 and his New York State income tax \$160, or a total of \$2,041. (Leslie Gould, Seattle Post Intelligencer, 3-26-52).

(Continued from Page 162)

Grievance Committee, one to be elected from each district. Nominations were: 1st District, Dr. J. A. Seigling of Charleston and Dr. W. A. Black of Beaufort. 2nd District, Dr. Weston Cook of Columbia and Dr. W. W. King from Batesburg. 3rd District, Dr. R. B. Scurry of Greenwood and Dr. R. L. Livingston from Newberry. 4th District, Dr. J. R. Young of Anderson and Dr. T. G. Goldsmith from Greenville. 5th District, Dr. Roderick MacDonald of Rock Hill and Dr. J. N. Gaston, Jr., from Chester. 6th District, Dr. Archie Sasser of Conway and Dr. Walter Mead from Florence. 7th District, Dr. N. O. Eaddy of Sumter and Dr. Keith Sanders from Kingstree. 8th District, Dr. W. R. Tuten, Jr., of Fairfax and Dr. O. Z. Culler from Orangeburg. 9th District, Dr. William Hendrix of Spartanburg and Dr. Joe Guess of Union.

Dr. Price moved, seconded by Dr. Wyatt, that Dr. Guyton of the State Board of Health be notified that Council wishes him to attend the National Meetings of the Civil Defense and represent the South Carolina Medical Association. The Association will share his expense.

Dr. Howard Stokes was nominated to succeed himself as Treasurer. This nomination to be presented to the House of Delegates.

Dr. J. H. Gressette moved that Council vote \$10,000 to the Medical School and earmark this sum for assistance in building student dormitories. This was seconded but the second was withdrawn; thus causing the loss of the motion.

Recess at 9:20 to meet at 8:30 a. m. on May 15th.

Respectfully submitted,
N. B. Heyward, M. D.
Secretary

**TEN POINT PROGRAM
OF THE
SOUTH CAROLINA MEDICAL ASSOCIATION**

1. Cooperation

To promote closer cooperation and better understanding between all agencies, groups and individuals concerned with providing and improving medical care for the people of South Carolina.

2. Extension of Medical Care

To study constantly the need and availability of medical care in each county of the State and in the State at large.

To promote plans for providing or improving medical care where is a need, particularly in the rural areas.

3. Pre-Paid Hospital and Medical Care

To make voluntary pre-paid hospital and sickness insurance available to all the people of the State (through Blue Cross, Blue Shield, and commercial insurance policies), and to promote the widespread purchase of such insurance.

4. Care of Indigent

To work with local county and state agencies, and with philanthropic organizations, toward securing good medical care for the indigent.

5. Public Health

To support the South Carolina State Board of Health in its broad program of preventing diseases and of safeguarding the health of our people.

6. Health Councils

To support the State Health Council in its announced program. To sponsor

the formation of a County Health Council in every county of the state, and to encourage our members to support and to work with these organizations.

7. Hospitals

To promote the expansion of present hospital facilities and the building of new hospitals—where there is a definite need.

To strive for highest standards of professional care in the hospitals in the State.

8. Medical Colleges

To support the Medical College of the State of South Carolina and to bend our efforts toward keeping its standards of education on a par with other medical colleges throughout the country.

To promote good nursing education and good nursing care throughout the State.

9. Education of the Public

To acquaint the citizens of the State with regard to the problems of medical care in existence today, to inform them as to what is being done to solve these problems, and to advise with them as to further plans for securing better health and better medical care for the people of South Carolina.

10. Political Medicine

To prevent political control or domination of medical practice or of medical education.

CHANGES IN THE MEMBERSHIP AND FELLOWSHIP STRUCTURE OF THE AMERICAN MEDICAL ASSOCIATION 1949-1952

1918 to 1949

Prior to 1950, and since the year 1918, all physicians who were members of their State Society were non-dues paying members of the American Medical Association. Of the 144,211 members of the A. M. A. in June, 1949, 77,723 were listed as fellows. Fellows paid dues to the A. M. A. and received THE JOURNAL A. M. A.

1949

The House of Delegates of the A. M. A. assessed all members of the A. M. A. \$25.00, but this assessment was voluntary and not compulsory. This was the only assessment made.

1950

There was no assessment in 1950. The A. M. A., for the first time, set the dues for membership in the A. M. A. at \$25.00 a year. If these dues were not paid by the end of the year the member was dropped for non-payment; before he could be reinstated, it was necessary for him to pay the delinquent year's dues.

The 1950 dues did not include a subscription to THE JOURNAL A. M. A.

A member in 1950 again had to pay fellowship dues to receive THE JOURNAL A. M. A., or could subscribe to it separately.

1951

The membership dues in the A. M. A. in 1951 were \$25.00 and included a subscription to THE JOURNAL A. M. A. Fellowship dues were reduced but no longer included a subscription to THE JOURNAL A. M. A.

1952

The same as 1951, except that there are no fellowship dues and fellowship cards are not being issued. Fellowship will probably be abolished after the Annual Meeting of the A. M. A. in June, 1952.

The following summary will further clarify the changes from 1949 to 1952:

MEMBERSHIP IN THE AMERICAN MEDICAL ASSN.	FELLOWSHIP IN THE AMERICAN MEDICAL ASSN.	SUBSCRIPTION PRICE OF THE JOURNAL A.M.A.
Membership dues in the A.M.A. never included Fellowship dues. Membership dues have been payable only through the County and State Societies.	Fellowship in the A.M.A. was dependent upon membership in the State and County Societies and the A.M.A. Fellowship dues were payable to the A.M.A. and were in addition to the membership dues.	Since January 1, 1951, the price of THE JOURNAL has been included in membership dues; rates below for 1951 and 1952 are for non-members, and laymen. Anyone may subscribe to THE JOURNAL.
YEAR		
1949 Assessed \$25.00 but payment not compulsory.	Dues of \$12.00 included THE JOURNAL A. M. A.	\$12.00
1950 Dues of \$25.00 did not include THE JOURNAL.	Dues of \$12.00 included THE JOURNAL.	12.00
1951 Dues of \$25.00 included THE JOURNAL.	Dues of \$5.00 did not include THE JOURNAL.	15.00
1952 Dues of \$25.00 include THE JOURNAL.	No fellowship dues for 1952.	15.00

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The Role of The Kidney in Sodium, Potassium and Water Metabolism

By

L. CORSAN REID, M. D.

Professor of Experimental Surgery—Post Graduate
Medical School
New York University

1. INTRODUCTION:

The role of the kidney in sodium and potassium excretion and water balance is the subject for this morning, which covers, as you will agree, a very wide territory. An attempt will be made to keep the discussion directed towards clinical problems. Constitution of the cellular environment is controlled principally by the kidney. If the kidney does not issue all of the orders it certainly is the organ where most of these orders are carried out. Everyone is familiar with the fact that everything that goes into the gut practically is reabsorbed and no discrimination is shown. On the other hand, the kidney shows a very highly developed selective action in removing undesirable substances that have gained entrance to the blood plasma. The role of the kidney in homeostasis is so fundamental that MacCallum has called it the organ of evolution par excellence.

To look upon the kidney as an organ of excretion is a very common error among physicians, besides being a most inadequate description of its function. The kidney is responsible for maintaining the electrolyte ratios of which we spoke yesterday, and surely this is an important role in itself. To facilitate handling this subject, sodium, potassium and water balance and the concentrating mechanism will be described separately.

2. MECHANISM FOR HANDLING SODIUM

The mechanism for handling sodium is best shown in this diagram of the kidney. Here is the glomerulus, first convoluted tubule, thin limb, distal tubule, and collecting ducts. The present accepted concept is that all electrolytes in 130 cc of blood are filtered every minute at the glomerulus entirely by physical processes, and in the first convoluted tubule approximately 85% of the sodium is actively reabsorbed.¹ Let us be very clear as to just what is meant by active

reabsorption of sodium. To put it very crudely and possibly over simplified, it means that sodium is picked up from the glomerular filtrate, transferred through the cell and pushed back into the blood with the expenditure of a considerable amount of energy. This means that the water now remaining in the tubule is hypotonic as compared to the blood. Now we have an osmotic force to explain the passive diffusion of water from tubule to blood. As a result of this state of affairs, the urine that is delivered to the distal tubule is isotonic. 15% of the sodium in the glomerular filtrate is reabsorbed actively in the distal tubule.

Therefore, the only sodium spilling into the urine is that in excess of the tubular ceiling. Let us take a crude example in convenient figures—if a thousand grams of sodium chloride are filtered by the glomerulus and 850 grams are reabsorbed in the proximal tubule and the 150 grams in the distal tubule and this constituted its ceiling, then if 1500 grams are filtered—1275 are removed in proximal tubule, but 225 are delivered to distal tubule whose ceiling is 150 grams, therefore, 75 grams spill into the urine.

Besides the mechanism for the conservation of base which we described yesterday, there is another odd mechanism with which clinicians should become familiar. If pressure is applied to the renal vein by clamp directly or even a tight abdominal binder—then sodium disappears from the urine, but potassium excretion remains unchanged. Indeed this back pressure in the renal vein in congestive failure explains some of the sodium retention and edema, so characteristic of the condition.² The mechanism of edema in congestive failure has been elucidated by Borst³ and Merrill⁴ Stead.⁵ For example, with decreased cardiac output there is less blood delivered to the kidney. 85% of the sodium in the glomerular filtrate is removed in the proximal tubule and 15% in the distal tubule, an amount which would be so far under its ceiling that it would be returned completely. None spills into the urine. Therefore, sodium retention. To

¹Lecture delivered before the South Carolina Medical Association, Myrtle Beach, May 15, 1952.

use our example again—if instead of 1000 grams of sodium being filtered at the glomerulus, the amount is now reduced to 500 grams. Then 425 grams will be absorbed in the proximal tubule leaving only 75 grams for the distal tubule whose ceiling is 150 grams. This is so far below its capacity that none spills into the urine. This mechanism of decreased blood flow to the kidney is of acceptable validity at the moment for explaining the edema so commonly present in this situation.

3. THE MECHANISM FOR HANDLING POTASSIUM

It has been believed until the last several years that the manner of potassium excretion by the kidney was a failure of total reabsorption. That is, all the potassium was filtrated at the glomerulus and that which appeared in the urine just did not get reabsorbed by the tubules. As a result of the work of Mudge et al⁶ and Berliner and his group,⁷ it now appears that under ordinary circumstances, this particular mechanism does not account for more than 20% of the potassium that appears in the urine. The other 80% is due to secretion of potassium probably in the distal tubule. Here again, one means by a secretory mechanism, that the potassium is picked up, is transported across or thru the cell and pushed into the urine with the expenditure of energy. This is a very revolutionary concept and explains some of those peculiar cases of the low potassium alkalosis syndrome.

To be more detailed about this statement, one can say that under many conditions sodium disappears out of the urine, as has been outlined above. But the mechanism for the conservation of potassium is at best quite unsatisfactory. Potassium spills constantly into the urine as long as there is an appreciable level in the blood. For instance in those cases of dehydration associated with alkalosis the potassium level in the blood falls, and the usual relationship between potassium and hydrogen ions in the kidney tubule is therefore upset. Under normal conditions there is a certain balance between the tubular activity in its excretion of hydrogen ions and in its secretion of potassium ions.

Now if you give a patient large amounts of potassium salts there is an excessive amount of potassium transported by the blood, normal levels are maintained by an increased secretion of potassium by the kidney. This increased potassium now takes up more than its share of a common pathway traversed by potassium and hydrogen ions. Accordingly the urine will be alkaline and the body fluids on the acid side, because there is a reduction in excretion of hydrogen ions. On the other hand if there is a low potassium level in the blood for any reason, the amount of hydrogen ions being spilled into the urine is proportionately increased.⁸ Therefore, one finds an acid urine and

alkalinity of the body fluids. This relation of the kidney to potassium and hydrogen ions explains the phenomena of a low potassium in the presence of an alkalosis, which can be treated satisfactorily only by supplying the required amount of potassium. Again, it might be pointed out, a low potassium level is associated with most obvious symptoms and is quite undesirable. While a high potassium is fraught with grave danger to life itself. In doubt, remember a low plasma potassium is bad, a high plasma potassium is dangerous.

This brings up a clinical problem of the utmost importance,—how are you going to get rid of body potassium in the presence of an anuria? One hears a great deal of talk about artificial kidneys, accompanied by some measure of a theatrical atmosphere about its utilization. However, its principal advantage is in getting rid of a high plasma potassium level. It is very comforting to know that if one has the misfortune to run into an anuria for any length of time, that a hyperpotassemia can be prevented by feeding the patient an adequate caloric intake in the form of butter and sugar exclusively. The high potassium levels in anuria of course are ordinarily due to the breakdown of tissue cells to provide fuel, and the liberation of potassium. To show how practical it is to maintain a normal plasma potassium level on a sugar fat regime—there was a case in Bellevue recently with an anuria of 39 days duration, in which all blood chemistries including potassium were within relatively normal limits. So that one can sum up the potassium situation by saying that 80% of the potassium appearing in the urine is a result of tubular secretion and only 20% on the basis of glomerular filtration. It might also be mentioned that orange juice contains approximately 5 milli equivalents per 100 cc's and is hardly suitable in anuria.

4. MECHANISM FOR THE HANDLING OF WATER

In the diagram of the kidney tubule you will recall that the proximal tubule reabsorbed 85% of the sodium. 85% of the water in the glomerular filtrate was removed passively from the first part of the tubule to the end of the thin limb. Now what does one mean by passively when compared to actively reabsorbed?

Well, we have seen that active reabsorption means pick-up, transport and unload. Now passive reabsorption means when you remove the sodium the fluid in the tubule is now hyposmotic. The fluids bathing the tubule are hypertonic and as a result of osmosis the water is swept from the tubule into the extra-cellular and vascular spaces. The urine delivered then to the distal tubule is again balanced or is isosmotic. At the distal tubule we have seen that sodium is actively reabsorbed. Again, we have the same passive reabsorption of water to follow the

sodium, if, and this is a very large if, there is present the A. D. H. hormone from the pars nervosa. Up until this year this reabsorption of water was considered to be an active process in which A. D. H. was an essential component of the enzyme system involved. Now of course it is felt that it is a passive affair, but A. D. H. must be present.¹² This is far from a settled affair. It is on this portion of the tubule that the adrenal cortex acts upon water excretion and remember, this is an action independent of, and separate from its relation to sodium. It would appear at the moment, as though the water reabsorbed by the distal tubule depended upon the balance between the A. D. H. and the water controlling factor in the adrenal cortex. This distal tubular control of water, that is about 15% of the glomerular filtrate is the only portion that is effected in diabetes insipidus, which has been designated by Homer Smith⁹ as facultative reabsorption, and the proximal tubule, thin limb, section as obligatory reabsorption.

One might well ask the question, "What controls the level of A. D. H.?" At the moment one can say that within the reaches of the internal carotid arteries there are structures which are sensitive to and form stimuli directed towards pars nervosa as a result of a change in the osmotic capacities of the blood.¹⁰ These osmo receptors are sensitive also, and respond to certain anesthetic agents as well as severe emotional disturbances. This explains the small volume of urine that one sees under emotional circumstances and sometimes after an operation.

To make this point crystal clear, one can say that in the distal tubule of the kidney the reabsorption of sodium increases osmotic capacities of the blood. This blood is carried to the osmo receptors, the pars nervosa is stimulated, A. D. H. is formed and more water is reabsorbed, until equilibrium is reestablished.

If for any reason there is a dilution of the plasma with a decrease in its osmotic capacities then there is a decreased number of stimuli from the osmo receptors, decreased formation of the A. D. H. the result being water is not reabsorbed in the distal tubule and a diuresis takes place, until equilibrium is again established. The role of the adrenal cortex appears to be essentially under most situations an organ for water excretion.¹¹ Every clinician knows how vulnerable Addison's disease is to water. This is an action separate and distinct from its role in retaining sodium and excreting potassium. In a rough way one might say for simplification that there is a dynamic equilibrium between the pars nervosa and the adrenal cortex in their control of water excretion. They appear to balance one another. They have their action on the distal tubule.

6. CONCENTRATING MECHANISM

The concentrating mechanism is the least understood of all phenomena that have been discussed in this

presentation, and there is considerable doubt as to where this takes place. Either in the lower end of the distal tubule or in the upper portion of the collecting tubule. It is perfectly true there is no experimental evidence to suggest that the distal tubule secretes water and therefore the only mechanism by which the urine could be concentrated, is that water is preferentially reabsorbed and by the same token, the only way the urine can be diluted is selective reabsorption of an electrolyte. The only electrolyte that is present in significant quantities is sodium. Only recently it was considered that this water reabsorption in the distal tubule and the concentrated mechanism were a single process, both of which were dependent upon the presence of A. D. H.¹²

It has become increasingly difficult to substantiate this concept, and at the moment it seems preferable to conclude that they are separate processes and that the concentrating mechanism regardless of its location depends upon removing a small quantity of water from a small volume of isosmotic urine. This concentrating mechanism does not depend on A. D. H., because in a completely diabetic insipid dog with dehydration a hypertonic urine can be produced as was shown by Shannon.¹³

SUMMARY

1. The greatest regulator within the body of the constancy of the cellular environment is the kidney, in which 4 main processes are involved. Filtration, reabsorption, secretion, and concentration.
2. 85% of the sodium in the glomerular filtrate is reabsorbed in proximal tubule. 15% is absorbed in the distal tubule. Both are active processes. Work is done. Energy expended.
3. 20% of the potassium in the urine is spilled at the glomerulus while 80% of the potassium appearing in the urine is due to tubular secretion. There is no mechanism for the conservation of potassium.
4. There is a passive obligatory process in the proximal tubule in which 85% of the water is reabsorbed. A facultative distal tubular process in which 15% of the water reabsorbed is also passive, but which does not occur in the absence of A. D. H.
5. Glucose is reabsorbed in the proximal tubule. Glucose is a diuretic for 2 reasons.
 1. It brings water into the blood stream without a covering base.
 2. At the ceiling for tubular activity of glucose reabsorption some increased sodium is spilled into the urine.
6. There is a concentrating mechanism either in the lower portion of the distal tubule or possibly the collecting ducts in which a small volume of water is removed from a small volume of isosmotic urine.

7. A simple sound and satisfactory approach to disturbances of Acid Base Balance and Water Equilibrium is to remember that sodium chloride solutions will repair any defect of the plasma except a ketosis where glucose has its most useful application and in low potassium associated with alkalosis and dehydration. It is of the utmost importance for clinicians to objectively visualize in terms of chemical diagrams, the altered plasma patterns, because this represents the only basis upon which one can have a thoroughly sound and rational therapeutic approach.

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Severe Potassium Deficiency Complicating Paralytic Ileus

WESLEY SEYMOUR, M. D.
and

C. WARREN IRVIN, JR., M. D.
Columbia Hospital, Columbia. S. C.

Severe potassium deficiency occurring following gastro-intestinal disease is a clear-cut and well authenticated clinical entity which, however, is not infrequently over-looked. The present case clearly demonstrates these points and in addition, striking electrocardiographic changes were noted which dramatically returned to normal paralleling the patient's improvement.

The patient was a 10 year old white male child who was first seen in the Columbia Hospital emergency room on 1-24-52, complaining of pain in his abdomen. His parents stated that the onset had begun five days prior to this date, with epigastric pain which later became localized in the right lower quadrant. Obstipation had been present for two to three days and he had begun vomiting during the last 36 hours. Further details of the history were non-contributory. On physical examination he was an extremely emaciated child who showed some evidence of dehydration and who was in acute distress. Pertinent findings were limited to the abdomen. Marked distention, tenseness and exquisite tenderness were present throughout. Rebound tenderness, spasticity of

the muscles and marked dullness to percussion were all present in the right lower quadrant. Active peristalsis was not audible. No masses were noted except on the rectal examination where a large mass was felt to protrude into the rectum from the right side of the pelvis. Admission laboratory work revealed a white count of 32,100 with a marked shift to the left, and a hemoglobin of 71%.

A diagnosis of appendicitis with perforation and abscess formation was made, and because of the rapid increase in distention, the abdomen was explored. Appendiceal abscess was found and drainage was instituted. No attempt was made to remove the appendix at that time and the abdomen was closed with multiple drains left in place.

Following surgery Wangenstein suction was continuously employed for the next eleven days and the patient was maintained entirely on intravenous fluids consisting of 1,000 cc's of 5% dextrose in distilled water alternated with 1,000 cc's of 0.9% saline daily followed by 1,000 cc's of 5% Amigen daily. The patient received two blood transfusions for a total of 500 cc's during this period of time. Specific therapy

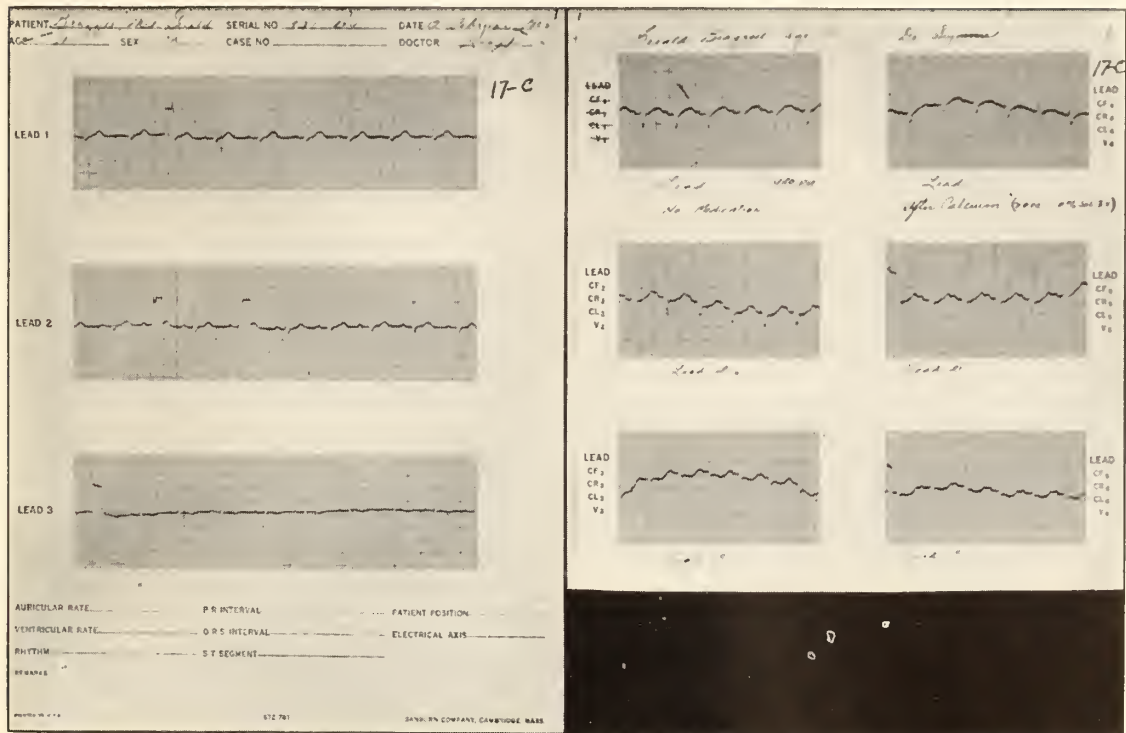


FIGURE I (Control on left)

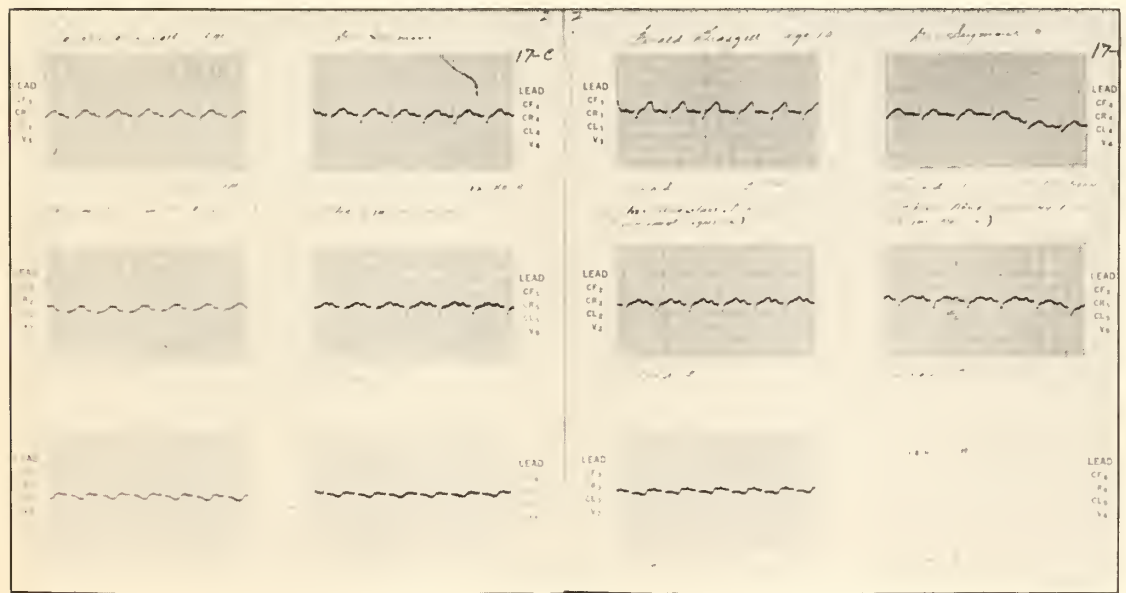


FIGURE II

of penicillin and streptomycin was given continuously but in spite of the treatment just outlined, the patient went progressively down-hill with continuous and steady increase in distention, failure to develop audible peristalsis and failure to expel flatus or have bowel movements. On the tenth post-operative day the patient was extremely ill. The carbon dioxide combining power of the patient's blood was found to be 58%. His blood chloride was 320 mg. (normal:

450-550). Because of the clinical condition and the result of the laboratory studies, the possibility of further electrolyte imbalance complicating the hypochloremia was considered and an electrocardiogram was ordered.

The initial electrocardiographic tracings showed typical evidence of extreme potassium deficiency with prolongation of the QT time and flattening of the T wave (rolling type). (See Figure 1.) Immediate

treatment was instituted in an attempt to correct the electrolyte imbalance. Because of the close similarity of hypokalemia and hypocalcemia, intravenous calcium was given without marked change of the electrocardiographic abnormalities. (See Figure 1.) Following this, intravenous potassium was given with frequent electrocardiographic observations. A total of 7.5 grams of potassium given over a period of 38 hours, all intravenously, was required for definite and adequate clinical and electrocardiographic evidence of improvement. Clinically, 12 hours after the onset of potassium therapy and after a total of only 3 grams of potassium, the patient exhibited marked improvement and had, for the first time, three loose, liquid stools. Electrocardiogram (See Figure 2) at this time showed only slight improvement. Three hours later after a total of 6 grams of potassium, slight but definite further improvement was noted (Figure 2). Further tracings showed continuous improvement but it was not until several days later that the tracing had returned to an entirely normal state (Figure 1, control tracing). The clinical improvement paralleled to a large extent the electrocardiographic changes and the patient continued to exhibit active peristalsis, decrease in abdominal distention and return of the deep reflexes. Within 36 hours the Wangensteen suction was removed and by 48 hours later he was eating a soft diet, sitting up in bed and was generally considerably improved. He subsequently underwent appendectomy and upon recovery from this was discharged.

DISCUSSION:

This case is an excellent example of the insidious and progressive development of extreme potassium deficiency while the patient was under careful observation in a hospital. The syndrome is quite characteristic and easy to diagnose if constantly kept in mind by attending physicians. The characteristic picture of asthenia, hypoactive reflexes, absent bowel sounds, anorexia, and failure to make proper clinical improvement should always suggest electrolyte imbalance even though careful attention to parenteral fluids has been given. The use of the EKG should aid considerably

in this problem. We were greatly impressed here with the electrocardiographic findings which were of extreme value both in diagnosis and treatment of the patient.

The patient had two primary factors operating to produce the severe potassium deficiency just described: 1. He had continuous Wangensteen suction—since the concentration of potassium in the gastric juice is two to three times that in the blood,¹ large quantities were doubtlessly lost in that manner; 2. In addition, no potassium was given to replace that lost daily via kidney excretion.

Intestinal and gastric atony have been previously described as part of the clinical picture of severe potassium deficiency.² Noting the rapid response in this case following intravenous potassium as regards the paralytic ileus, it would seem that the ileus was at least in part due to the existing deficiency of potassium.

The EKG changes were typical of severe potassium deficiency³ and the reversal of these abnormal tracings closely paralleled the clinical response.

In concluding it would seem worthwhile to restate the importance of careful *total* electrolyte studies in the post-op patient, with special emphasis on the value of the EKG in detecting and following treatment of potassium deficiency. It would further seem that if a patient is to be maintained on parenteral fluids exclusively, the average daily requirement of 3 grams of potassium should be met in the parenteral feeding.

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Acute Idiopathic Pericarditis

A. IZARD JOSEY, M. D.*
Columbia, S. C.

What is currently being called benign acute idiopathic pericarditis, acute benign pericarditis or virus pericarditis may be a disease, but under the usually accepted criteria of a disease it varies so much in its manifestations and course that it can hardly be accepted as such. There has been a dearth of pathological studies and the etiology is not known. In many in-

stances it is preceded by or accompanied by a respiratory infection which is usually accepted as virus in nature, but this is not true in a large minority of instances. The course of the disease varies from a few days to several months and relapses are frequent. In about half of the reported cases a leucocytosis is found and in the other half a normal or lowered leucocyte count is reported. In addition to the conjecture that there is a viral etiology other suggestions have been that the syndrome is related directly to a streptococcus infection or an allergic response to an in-

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fectious agent. In all of the cases the diagnosis must always be made by elimination of other better recognized causes of pericarditis. It is difficult in reported cases accurately to determine whether pericardial effusion is frequently or infrequently an accompaniment. The question is always present as to whether myocarditis always, or only sometimes accompanies the syndrome. Certainly, it is not a new disease. Dr. Hodge of the Massachusetts General Hospital, as quoted by Carnichael et al,¹ described what was probably a case of this type in 1854. Morrison in 1906 and Cromer in 1927 described several cases probably of this syndrome.¹ The modern concepts of this interesting syndrome begin with its description by Barnes and Burchell² in 1942. These authors incidently relate the review of one case occurring in 1923 and one in 1930 who were originally thought to have myocardial infarction but who in retrospect had idiopathic pericarditis.

In most instances the patient, who may be male or female, young or old, describes an upper respiratory infection of a mild or moderate nature which was usually not incapacitating. There may or may not be an interval of a few days and the syndrome is ushered in by an attack of acute anterior chest pain. In the classical instance this pain is sharp, severe, and stabbing, increased by deep breathing, coughing, torsion of the body or the supine position. Located in the substernal or precordial regions or even in the right upper quadrant, the pain at times radiates to the left shoulder and arm or both of these. This pain is usually severe though it may be of only mild degree. Variable in duration, it usually persists for from one to several days and may even come and go for several weeks. At times the onset may be less abrupt over a period of a week or more. There is usually accompanying fever of from 99°F. to 102°F.

If the patient is carefully observed early in the course a precordial friction rub is heard in a high percentage of the cases. This friction rub may be of only a few hours duration but usually persists for two to three days though at times it is heard at intervals for several weeks. The heart rate is usually rapid but may be only slightly increased. The rhythm is regular but a gallop is heard at times in the more severe cases. During the early course the heart is not enlarged, however, where the syndrome runs a prolonged course the outline of the heart is enlarged, at times grossly, both to the left and the right. Where effusion of any great amount is present a paradoxical pulse can usually be demonstrated. Pain and a precordial friction rub occasionally persist even where demonstrably large amounts of fluid are present in the pericardial sac. After the exudation of pericardial fluid begins the heart sounds usually become muffled, but not necessarily so. Pericardial tap for therapeutic effect on tampanard rarely becomes necessary in this syndrome. It has been done frequently for diagnostic purposes. The fluid may be clear amber but frequently is serosanguineous. It contains relatively few leuco-

cytes and is sterile for pyogenic organisms and the tubercle bacillus. There have been no reports of virus studies. The blood pressure is not usually changed from its ordinary level but may be elevated due to pain and anxiety. The lungs frequently show evidence of non specific infection with scattered rales. Pleural effusion is present in a small percentage of cases. Symptoms and physical findings consistent with congestive failure are present in the more severe cases during the course of the illness. The dyspnea seen is usually due to painful respirations, but in cases associated with congestive failure it is of a different character. There are no specific findings in the urine or blood. The leucocyte counts may be lowered, normal, or elevated to above 20,000 per c mm. with polymorphonuclear predominance.

The EKG findings are quite important in the diagnosis. Early, within a few hours, there is elevation of the ST segment of more than 1 millivolt in at least two of the limb leads and frequently of the chest leads to the left without reciprocal depression. There is no reciprocal ST depression. These changes are frequently quite effervescent and although the ST segment elevation may persist for several days the usual occurrence is a lowering of the ST segment and at the same time a lowering of the T waves within a few days. Within several days the T waves become sharply inverted. At no time does a Q wave develop and the ST segment does not become depressed. In some of the mild cases of short duration the flattening and inversion of the T wave fail to develop. After the T waves become inverted they remain so for an indeterminate length of time from a few days to several months, depending in all probability on the duration of the pathological process. However, in almost all of the cases there is an eventual return to a normal EKG pattern.

X-ray of the chest early in the course reveals normal findings as far as the heart is concerned. In a number of cases pulmonary changes of lobular pneumonia and in a few, a small to moderate pleural effusion is found. Except in the mild and effervescent cases the size of the cardiac shadow becomes enlarged over a period of seven to ten days and may assume immense proportions. It usually assumes a globular shape and all the usual contours of the heart are obliterated except that the acute cardio hepatic angle may be retained. At this stage the normal ventricular contractions, as usually seen by fluoroscopy, are absent or markedly reduced. Another important determination is the preceptible increase in width of the shadow in the second interspace between films in the upright and in the supine positions taken at the same distance, usually three feet. If this measurement is over one centimeter it can be considered diagnostic of pericardial effusion.

The mild or effervescent cases recover within one to a few days. The more severe case is sick or confined for several weeks before symptoms disappear. Return

of the electrogram and x-ray size of the heart to normal may be even more prolonged. Carmichael¹ cites one case which was prolonged clinically for seventy days. The long term outlook is good. The literature, thus far, reveals only one fatal case attributed to the syndrome by McCord and Taguche.³ This case was thought, at first, to have a coronary thrombosis, was given dicumeral and developed excessive bleeding into the pericardial sac, dying as a result of this complication. At autopsy the pericardium was found to be thickened and adherent with multilocular cavities. The myocardium was of normal thickness, there was no dilatation of the chambers, the valves were normal, and there were subendocardial hemorrhages. Microscopically there was a fibrinous exudate on the pericardium with infiltration of polymuclear cells and lymphocytes in the pericardium and contiguous myocardium with some fragmentation of the heart muscle.

Relapse or recurrence of the syndrome is rather frequent. Carmichael¹ reports recurrence in 18% of his fifty cases. He and Levy⁴ cite cases with as many as four recurrences. Recurrences are usually not as severe or prolonged as the original attack. Eventual recovery within a few weeks or months is practically assured in this syndrome. Instances in the literature of prolonged follow up of cases are somewhat meager. Levy⁴ has followed seventeen cases for over two years following an attack of acute pericarditis and none had any symptoms or signs of heart disease. Carmichael¹ followed forty five cases for two or more years, nineteen of them for over five years, and none had any symptoms or x-ray findings referable to the original attack of pericarditis. Six cases showed minor EKG changes which, in only three cases, were thought probably to be referable to the original attack of pericarditis. In none of the cases of Levine or Carmichael, nor any other reported cases of the syndrome, was the evidence of constrictive pericarditis demonstrated.

DIFFERENTIAL DIAGNOSIS

Although a presumptive diagnosis of acute idiopathic pericarditis can be made early in its course, a more firm conviction must await further developments and the passage of time. It occurs in the young and old of both sexes and in white and negro races. There are many specific causes of pericarditis: acute rheumatic fever; tuberculosis; myocardial infarction; pyogenic infection including pneumonia and empyema, streptococcus infection, tularemia, uremia, lupus erythematosus; sickle cell anemia; and Hodgkins disease. All of these must be constantly thought of when one is considering the diagnosis of acute idiopathic pericarditis. In the younger age group acute rheumatic fever is to be principally borne in mind. Joint pains, previous attacks resulting in valvular disease, presence of significant murmurs and corollary signs of repeated epistaxes and erythema nodosa are valuable sign posts. Increased PR interval in the EKG frequently occurs in acute rheumatic fever but not in idiopathic

pericarditis. In the older age group when myocardial infarction is to be considered there are several helpful points of interest. The presence of fever at the onset and absence of shock makes one lean away from coronary thrombosis. The type of pain is a little different in pericarditis. It is more related to respiration and position. In coronary thrombosis the blood pressure usually falls while in pericarditis no particular change occurs. The EKG is important. The only change found early in pericarditis is elevation of the ST segment in several leads, while in coronary occlusion a Q is usually present and the ST elevation in either anterior or posterior infarction is accompanied by reciprocal depression. The T waves in pericarditis are not inverted until the ST segment has returned to the isoelectric line. Later the differentiation becomes more evident with sharp inversion of the T waves in multiple leads, without a Q wave. Tuberculous pericarditis offers a different problem. The onset is usually more insidious and although the pain of pericarditis may be present the symptoms and signs of a generalized and pulmonary disease predominate. The cardiac findings, EKG and x-ray signs may be quite similar. There are usually concomitant pulmonary physical findings and the sputum and the pulmonary x-ray findings are most often sufficient to lead one to the proper conclusion. In a few cases only the long term view will indicate the proper diagnosis. In the other causes of pericarditis there are usually sufficient corollary findings to lead to the diagnosis although one must always keep in mind such rare diseases as lupus erythematosus.

The question of non specific myocarditis frequently enters the picture. Myocarditis is a term which was used rather loosely for many years by the profession and in the last two or three decades has become frowned upon. Saphir⁵ has shown that myocarditis often occurs in relation to acute infections. In the syndrome of acute idiopathic pericarditis evidence of cardiac involvement frequently occurs. How much of the disturbances is caused simply by pericardial inflammation with pericardial effusion and how much is dependant on myocarditis is a persistent question. Carmichael et al¹ attributed the cardiac enlargement, noted in 25% of their fifty cases, to pericardial effusion in only three instances and thought that cardiac dilatation accounted for the other twenty two. However, they do not recite the important procedure of upright and supine x-ray films and they themselves question how such a great amount of dilatation could occur without evidence of myocardial insufficiency. Several authors have assumed that the marked cardiac enlargement was not due to increased pericardial fluid because attempts at paracentesis have failed. This is not necessarily true as successful pericardial taps may be difficult. Levine⁶ cites one instance where repeated unsuccessful attempts to obtain pericardial fluid by tapping anteriorly was followed by removal of 500 cc. when the needle was inserted posteriorly. There is good evidence, however, that the

condition is not simply confined to the pericardium and the contiguous myocardium. Carmichael,¹ Burchell,⁷ Logue and Wendkos⁸ consider that myocarditis plays a definite part in a number of cases. Supporting this idea is the fact that congestive failure, other than related to tampanard, is not infrequently seen as a part of the picture of the syndrome.

TREATMENT

Due to the considerable degree of variability in the course of this syndrome the effect of any specific therapeutic agent offers great difficulty in evaluation. Most of the authors reporting on such cases have not considered any specific treatment. Logue and Wendkos⁸ tried penicillin and sulfonamides without effect. Taubenhaus and Brams⁹ used aureomycin on three cases and thought the drug produced prompt relief, but they admitted that the course of the syndrome was so variable that no conclusions could be drawn from their results. One of the cases in the present series who appeared acutely ill, and had fever 103° F. and a gallop rhythm, received ACTH with prompt subsidence of evidence of disease and ran a very short course. In general the presently accepted treatment is symptomatic with the use of narcotics for relief of pain and bed rest until symptoms and signs subside. Pericardial paraecentesis may be necessary at times for relief of symptoms of tampanard. In the severe case symptoms of congestive changes appear and digitalization and mercurial diuretics have been employed with excellent results. In most cases when the chest pain subsides the patient is relatively quite comfortable. The problem of enforcing bed rest may offer difficulty in a few cases and in several of our cases the patients, not being impressed with their illness have left the observation of the physician against advice.

This series of thirty nine cases in this report are from three sources—16 from the Veterans Administration Hospital, Columbia, S. C., 7 from the staff service of the Columbia Hospital, 11 from my private practice and 5 private cases of my colleagues in the Columbia Hospital and cover the years 1945-1951, figure 1. In addition to my private cases approximately half of the cases from the Veterans Administration Hospital and all of the staff cases from the Columbia Hospital were observed by me. The remainder of the cases were subjected to a critical review of their hospital records. The criteria for inclusion in this group were principally a history of chest pain, specific electrocardiographic changes, absence of a specific etiology for pericarditis and in all but two cases a benign course. Pericardial rub when heard was considered diagnostically important but its absence was not disconcerting. These cases are classified arbitrarily into mild, 12—moderate, 19—and severe, 8.

The mild cases may have severe pain at onset, but the pain was of only one to four days duration, fever lasted only one to four days, the heart was not demonstrably enlarged and the patient was asymptomatic

	V. A. Hospital	Columbia Hospital	Private cases	Total
Patients	16	7	16	39
Mild course	4		8	12
Moderate course	8	4	7	19
Severe course	4	3	1	8
Friction rub	2 (mild) 3	2	2 (mild) 1	11
Normal WBC	4 (mild) 10		3 (mild) 6	26
Leucocytosis	2	3	5 (mild) 1	11
Pulmonary infiltration	4	3	2	11
Pleural effusion	4	3		7
Pericardial tap	1	3	2	6

Figure 1

FIGURE 1
Analysis of 39 cases of idiopathic pericarditis.

in one to seven days. Frequently the only EKG change was an elevation of the ST segment in one or more of the limb leads or the chest leads to the left, returning to normal in three to twelve days without the T waves becoming inverted.

In the cases running a moderate course, the illness with pain and fever was more prolonged. The area of cardiac dullness and the x-ray shadow became enlarged for a period varying from a week to several months. The EKG progressed from the phase of ST segment elevation to that of inversion in two or more limb leads and the chest leads to the left. This pattern did not return to normal for several weeks or longer. Evidence of pulmonary infiltration was demonstrated by x-ray in ten cases and in six cases there was a pleural effusion. Several had recurrence of the symptoms after several weeks or months.

In the eight severe cases the additional factor of myocardial insufficiency appeared. This group illustrates the type of case in which unquestionably myocarditis is a factor. Some may question inclusion of this group in the same syndrome as idiopathic pericarditis. However, clinically they do not differ from the other cases in the group of moderately severe ones other than the appearance of congestive failure. The electrocardiographic pattern was the same and the x-ray findings are quite similar. But how much of the cardiac enlargement is due to cardiac dilatation and how much to pericardial effusion was not accurately determined. Pericarditis is probably the primary factor and in addition the disease process extends into the myocardium sufficiently to produce myocarditis with resultant myocardial insufficiency. In one case, having a severe course with evidence of congestive failure, pericardial paraecentesis was productive of a sero-sanguineous fluid. He became asymptomatic in about six weeks and the heart size became normal although the T waves were still inverted on discharge from the hospital. In no instance was tampanard thought to be the cause of the heart failure and none required pericardial paraecentesis for relief. In six of these cases

the administration of digitalis and mercurial diuretics produced prompt relief of congestive symptoms and they had a salubrious course. Two cases died during the course of their illness. Unfortunately an autopsy was not obtained in either instance. The first case was suffering a relapse of pericarditis with congestive failure and died principally from hematemesis probably caused by a peptic ulcer. The second death was in a colored male, age 55 years who had a concomitant chronic urinary tract infection. During the course of his illness he developed a psychotic episode and on one occasion he jumped from the hospital window. He died suddenly and the cause of death could not be determined, but it was probably due to myocardial failure.

The following are four illustrative cases:

Case 1—J. A. R., white male, age 20 years, had suffered for eighteen hours moderate precordial pain, worse on deep breathing when seen on February 10, 1949. Temperature 99.8° F., pulse 84, blood pressure 124/84, leucocyte count 8,200. Deep breathing was painful. The lungs were clear. The heart was regular, a pericardial friction rub was heard just to the left of the sternum. EKG showed elevation of the ST segment in the chest leads only, figure II. The heart was normal

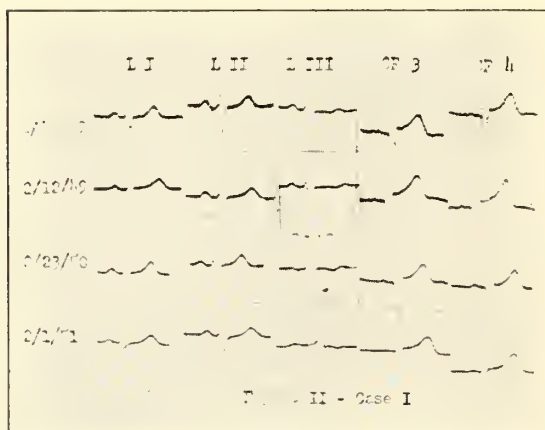


FIGURE II

Electrocardiograms of case 1 (J. A. R.), ST elevation in chest leads only.

in size by fluoroscopic examination. After a narcotic he became asymptomatic and remained so and later in the day the friction rub disappeared. There was an elevation of temperature to 99° F. plus for three to four days. After six days hospitalization he rested at home for a week. At the end of that time the EKG showed only slight elevation of ST in CF 3 and CF 4 and the heart was of normal size on fluoroscopic examination. He was then allowed his usual activities and remained asymptomatic. On February 1, 1950 and on October 2, 1951 the EKG and fluoroscopic of his chest were normal.

Case 2—L. W. H., white male, age 40, developed

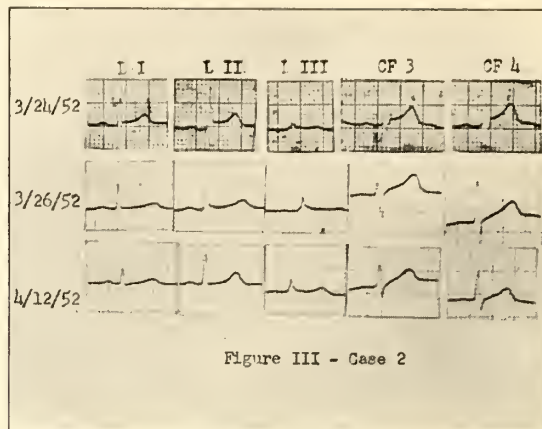


FIGURE III

Electrocardiograms of case 2 (L. W. H.), ST elevation in leads I, II and CF 3 and CF 4 with return to normal within 48 hours.

sharp pain in the right anterior chest in the late afternoon of March 23, 1952. Pain soon spread to the epigastrium, retrosternal and lower neck regions and was increased by inspiration and coughing. He was hospitalized and given morphine with relief of the pain. However, the pain returned after eighteen hours and remained for practically twelve hours when all symptoms disappeared, not to return. Temperature 99.4° F., pulse 84, and blood pressure 110/70, leucocyte count 13,600. The lungs were clear. The heart was normal in size and there were no murmurs or friction rub heard. EKG showed elevation of ST segment in leads I, II, III and CF 3 through CF 5, figure III. These changes were present to a lesser degree on March 26, 1952. By April 12, 1952 the EKG tracing was normal. The heart and lungs were normal on fluoroscopic examination on March 31 and on April 12, 1952. He has remained asymptomatic.

Case 3—H. H., white male, age 43, had symptoms of a mild respiratory infection for two or three days, then developed severe precordial pain referred to both shoulders and left upper arm requiring several narcotic injections for relief, on the night of October 7, 1950, and lasting about twenty four hours. In the past he had been generally healthy and his systolic blood pressure had ranged between 100 and 120. When examined by me on October 9, 1950 he was comfortable and afebrile. The heart sounds were normal, pulse rate 88, blood pressure 110/80, leucocyte count 7,200. The EKG on October 9, 1950 showed a questionable elevation of the ST segment in leads I and II, figure IV. On October 11, 1950 there was slight but definite elevation in lead II and CF 3 and CF 4. X-ray of the chest was normal, figure V. On the nights of October 11 and 12 there was some return of the chest pain. On October 14 the ST segments were lower than on October 11. He returned to his usual activity. On November 7, 1950 there was a return of similar chest pain radiating to the left shoulder with some epigastric pain which was increased on

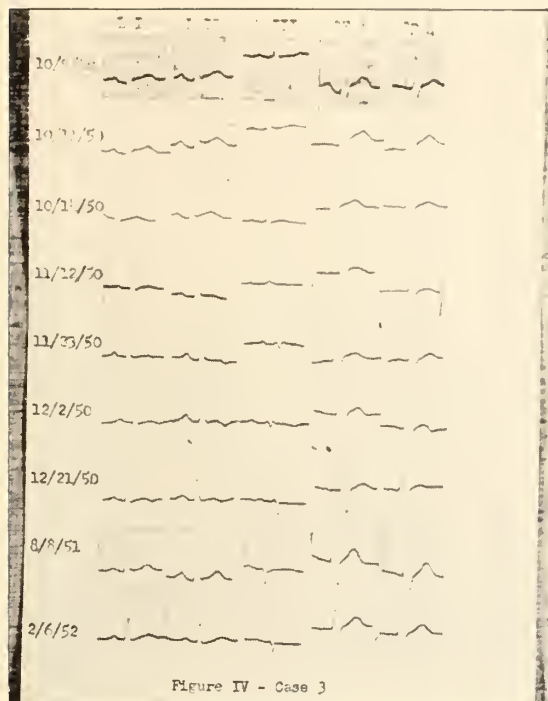


Figure IV - Case 3

FIGURE IV

Electrocardiograms of case 3 (H. H.). Early elevation of ST segment in multiple leads with progression to inversion of T in leads I and II and later return to normal.



FIGURE V

Serial x-rays of chest of case 3 (H. H.). Heart of normal size on October 9, 1950 and enlarged on November 13, 1950. Erect and supine x-ray films at distance of three feet on November 13, 1950.

deep breathing. On November 12 the heart sounds were found to be distant and on x-ray the cardiac shadow was definitely enlarged, globular in shape and with increased width in the supracardiac area in the supine position, figure V. The ST segments were isoelectric but T I and T II were of low voltage. By November 23 there was low voltage of T I and inversion of T II and by December 2 inversion of T I, II, and III and CF 4, figure IV. On December 21, 1950 there was no significant change but by January 10, 1951 the EKG had returned to normal. On December 21, 1950 fluoroscopic examination showed the heart shadow to be normal in size and shape. In the meanwhile the patient had only an occasional elevation of temperature of 100° F. and slight precordial pains and dyspnea. He remained in bed fairly com-

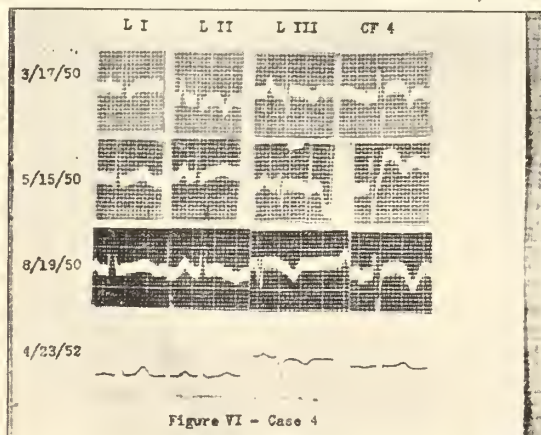


Figure VI - Case 4

FIGURE VI

Serial electrocardiograms of case 4 (W. L.). Inverted T in leads II, III and CF 4 with flat T I on March 17, 1950. Return toward normal two months later. Recurrence of changes on August 19, 1950. Normal tracing, except for inverted T III on April 23, 1952.

fortable from November 12 to December 6 when he was allowed to be up. After January 10, 1951 he was allowed increasing activity. Since then he has had only occasional mild fleeting left anterior chest pain. Further fluoroscopic and EKG examinations on August 8, 1951 and February 2, 1952 were normal.

Case 4—A negro man, age 36, had been in good health until about mid January, 1950 when he developed right upper quadrant pains followed by dyspnea. When admitted to the Veterans Administration Hospital in Columbia, S. C. on March 16, 1950 he was acutely ill with symptoms of congestive heart failure. He was afebrile, his heart was moderately enlarged and there was a soft systolic murmur over the precordium. The pulse was rapid and blood pressure was 100/76. There were many basal rales and the liver was enlarged and tender but there was no oedema of the extremities. Leucocyte count was 7,550. Sick cell preparation was negative. X-ray showed the heart to be greatly enlarged to the left and right, figure VII. EKG on March 17 revealed a flat T I and inverted T in leads II, III, and CF 4, figure VI. The patient was treated with digitalis and showed rapid

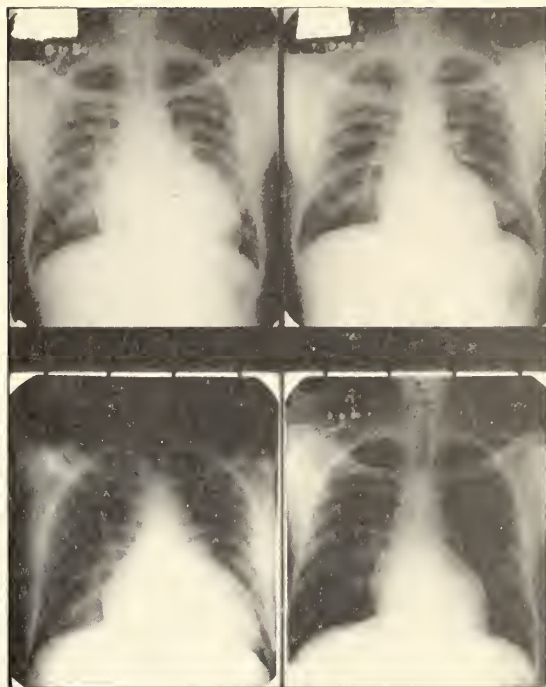


FIGURE VII

Serial x-ray films of chest on case 4 (W. L.). Heart shadow enlarged on March 17, 1950 with return to normal on May 16, 1950. On August 18, 1950 heart again enlarged and again returned to normal size on September 5, 1950.

improvement, becoming asymptomatic in four to five days. The heart was practically normal in size by March 23, 1950. The EKG also showed a return toward normal by April 6 when T II became upright. On May 15 the T waves were upright on the limb leads but inverted in CF 4. He was asymptomatic on discharge on May 15, 1950. However, on August 15, 1950 there was a return of similar symptoms and he was readmitted to the Veterans Administration Hospital on August 18, 1950. He was dyspneic, the heart was enlarged and there was a gallop rhythm. Blood pressure was 110/76. Basal rales were present and the liver was enlarged and tender. The leucocyte count was 8,000. X-ray again showed marked enlargement of the cardiac shadow, figure VII. The EKG showed a diphasic T I and inverted T in leads II, III and V 4. Again he improved on digitalis and became asymptomatic within a week. X-ray on August 22 showed a decrease in the size of the heart shadow and on September 5, the heart was normal in size. The EKG showed a return toward the normal. He was discharged on September 15, 1950.

Since that time he has worked regularly as a driver for an auto company. He has had some minor, fleeting left chest pain but no dyspnea on ordinary exertion. He had taken digitalis daily to April 10, 1952. When re-examined on April 23, 1952 he was asymptomatic, the heart sounds were clear, pulse rate 72, and blood pressure 138/92. On fluoroscopic examination the left

ventricle appeared rounded but the heart size was within normal limits and the EKG was normal, figure VI.

DISCUSSION

Among the 39 cases, 28 were male, 11 female, 23 white and 16 negro. The youngest was a white male, 20 years old, the oldest a white woman of 77 years. Fifteen cases were forty years of age or older and a number of these were naturally suspected of having coronary insufficiency or thrombosis at the onset. Thirteen cases had their onset during the winter months, twelve in the spring, five in the summer and nine in the fall. Follow up on most of the cases has not been adequate but four private cases followed for over two years have remained free of cardiac symptoms, two for five years or more. None of the survivors in the group are known to have retained any evidence of permanent cardiac symptoms. Two of the cases were thought to show evidence of fixation of the electrical axis of the heart. Auricular fibrillation was the only arrhythmia noted in this series and occurred in only one case which was severe. It is of interest to note that the woman of 77 years (A. F.) seen in June, 1947 had a moderately severe course with severe substernal pain at onset with dyspnea and temperature of 102° F. to 103° F. for over two weeks. The electrocardiograms and x-rays were typical of pericarditis with effusion. Pericardial tap produced 150 cc. of serosanguineous fluid. She recovered symptomatically in a period of six weeks and at the end of ten weeks the heart was normal in size and the EKG was normal. At the last communication with her on April 3, 1952 she was well and quite active.

During the same period of time that these cases of idiopathic pericarditis were observed, it is of interest to note that at the Veterans Hospital in Columbia, S. C. there were five cases of tuberculous pericarditis, one case due to tularemia, two cases due to a purulent organism, one case of myxedema heart with a large pericardial effusion but without evidence of pericarditis by electrocardiogram, and one case of leiomyosarcoma of the right auricle with pericardial effusion. One case, not included in the series, ran a course similar to benign pericarditis but because of accompanying symptoms of arthralgia it was thought that acute rheumatic fever might be the etiology. In the Columbia Hospital staff group there was one case of indeterminate etiology with congestive failure and pericardial effusion whose EKG tracings failed to show typical changes and was not included in this series. One case originally thought to have benign pericardial effusion later showed evidence of tuberculosis. There was one case of sickle cell anemia at the Columbia Hospital who showed EKG changes of pericarditis and who on autopsy showed in addition to other findings of sickle anemia a serofibrinous pericarditis. It is interesting to note that a higher percentage of mild cases, eight among sixteen, occurred among those seen in private practice. These cases received earlier medical care than the other groups and had

lessened morbidity probably because of this fact. Or it may be that only the more prolonged cases admitted themselves to the other type of services. But in general from a review of this series of cases it appears that those individuals who received bed rest promptly after the onset of chest pain ran a much shorter course of illness. However, this is not absolute as several cases who had prompt bed rest ran a course of several weeks. No other helpful deductions as to treatment could be determined in this group of cases although penicillin and aureomycin were used in a number of instances. As previously noted, one case (J. F.) who appeared acutely ill with a pericardial friction rub, pulse rate 140, temperature of 103° F. and a gallop rhythm, recovered promptly after being given ACTH. In the severe cases that developed congestive failure, digitalis and mercurial diuretics were quite helpful.

CONCLUSIONS

What is usually called idiopathic pericarditis is probably not a clinical entity but may have a varied etiology. The diagnosis should be suspected early, by the presence of chest pain increased by respiration and position; possibly prior respiratory infection; fever; electrocardiographic changes of an elevated ST segment in multiple leads progressing, in other than the mild cases, to sharp inversion of the T waves in one or more of the limb leads and the chest leads to the left, without the presence of a Q wave; and the development of x-ray evidence of an enlarged heart. A confirmed diagnosis must await the passage of further time and close observation. Other more specific forms of pericarditis and pericardial effusion must be always kept in mind. As soon as possible the differentiation from a myocardial infarction should be made due to the difference in prognosis. The increased heart size is probably produced largely by pericardial effu-

sion. The course of the syndrome is quite variable but a high percentage of cases have a duration of illness of only a few days. Myocarditis is most certainly a factor in the severe cases where congestive failure occurs. In those cases who show evidence of myocarditis with congestive failure digitalis and mercurial diuretics are helpful. Other than bed rest and narcotics for relief of pain no other therapy has been shown to be of value. The ultimate prognosis is usually good. Although the few reported fatalities have been related to complicating circumstances and diseases, the severe cases with myocarditis do offer danger to life.

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CANCER

Edited by JOHN C. HAWK, JR., M.D., Charleston, S. C.

ERYTHEMA ELEVATUM DIUTINUM A CASE REPORT

JOHN VAN DE ERVE, JR., M. D.

H. R. PRATT-THOMAS, M. D.

JOHN C. HAWK, JR., M. D.

Edited by JOHN C. HAWK, JR., M. D.

(Editor's Note: This month we depart from our usual custom of presenting a general or review article in order to give a case report of an unusual condition for which new and previously unreported modes of therapy have been tried, but without success.)

There exists a nondescript group of conditions, characterized in common by some degree of prolifera-

tive or lymphoblastomatous change, about whose origin and nature, whether neoplastic or inflammatory, there remains considerable doubt and controversy. Included in this group are Hodgkin's disease, the leukemias, lymphosarcoma, mycosis fungoides, Kaposi's idiopathic hemorrhagic sarcoma, and erythema elevatum diutinum. A case has recently been encountered by the authors which has features of both of the latter two conditions and which seems of sufficient interest to be worthy of a case report.

Multiple idiopathic hemorrhagic sarcoma was described by Kaposi¹ in 1872 as a relatively benign vascular connective tissue growth, which usually appears in multiple lesions on the extremities, especially the legs, but in many instances may also involve the mucosae, lymph nodes, and viscera, and after a pro-

From the Departments of Dermatology, Pathology and Surgery and the Cancer Clinic, The Medical College of South Carolina, Charleston 16, S. C.

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tracted course may result in death. The etiology of this disease is entirely unknown, although some consider it a form of vascular neoplasm. Men are affected more often than women, generally after the fourth decade of life. The early lesions appear on the hands and feet as red, purple, or blue-black nodules of a rubbery or firm consistency. These lesions may be either poorly defined or discrete and may coalesce into plaques. Vesicles and bullae due to lymphedema may occur. Later, nodules may appear on the face, ears, trunk, buccal mucosa or other areas. The lesions may suggest granulomata, angiomas, or neurofibromata. The course of the disease is slowly progressive, new nodules developing, and gradually leading to marked and slowly progressive enlargement of the extremities, lymphedema and malodorous ulceration. There may be periods of remission. Nodules may be moderately tender, but they cause no severe discomfort until the terminal stages when the parts are swollen and ulcerated. Leukemia, mycosis fungoides or true sarcoma may develop in some cases.

Erythema elevatum diutinum was first described under this name by Crocker and Williams² in 1894, although Hutchinson³ probably furnished the first descriptions of typical instances of this disease some years earlier. Erythema elevatum diutinum is a persistent type of annular erythema resembling granuloma annulare and believed by some to be a clinical entity. The lesions are elevated, flat, purplish plaques, which occur most often over the joints of young women. The lesions are symmetrical, being located definitely over points of pressure and are highly colored. The histologic picture is that of vascular hyperplasia with infiltration of polymorphonuclears and eosinophiles, but usually no necrosis. This is a very rare disease, and while it is thought to be a part of the erythema multiforme and granuloma annulare groups, nothing is definitely known of its exact cause and classification.

Case Report: R. M. S., a Caucasian male, age 38, was first seen by one of the authors (J. v. d. E.) in January, 1949 with a bizarre eruption, present for two and a half years. Plaques of livid purplish color, elevated, firm and very tender had begun to appear on the elbows and knees in the summer of 1946, and during the following year had spread gradually to involve the dorsum of the hands and the dorsal and plantar surfaces of the feet. These lesions had become so tender that the patient had difficulty in continuing his work. A series of injections of bismuth had been given previously. Finding of fungi in plantar vesicles had caused confusion as to the etiology of the pedal dermatitis.

The disease was described in January, 1949 as follows: "An eruption of annular, elevated, firm, red to purple, livid nodules and plaques on the dorsum of the hands, on the heels and dorsum of the feet (the lesions on pressure areas showed markedly verrucous sur-

faces) and heavily distributed over the nates and posterior thighs. One lesion is evident on the right postauricular area." It was felt that Kaposi's sarcoma, sarcoid, xanthoma, erythema elevatum diutinum, and all of the granulomas and lymphoblastomas had to be considered in the differential diagnosis. A biopsy was taken and pathologic study revealed a chronic inflammatory reaction with conspicuous vascular proliferation. Within the corium were lymphocytes, mononuclear cells and eosinophiles which were closely related to angiomatous accumulations of blood vessels. The inflammatory process often involved the vessel walls so as to constitute a subacute arteritis. The angiomatous proliferation did not appear sufficiently active to justify a definite diagnosis of Kaposi's disease. Subsequently, large vesicles and bullae developed on various parts of the body and were thought possibly to denote pemphigus, erythema multiforme or acute lupus erythematosus.

The patient was treated conservatively with tinctures and local soothing applications for two months without improvement. Some of the verrucous lesions on the feet were given x-ray therapy (1000 r, 86 K.V., 5 M. A., 15 cm. TSD, no filtration) with no result except the development of temporary sensitiveness. This was contrary to the response expected of Kaposi's disease.

Following March 16, 1949 the patient was not seen by the authors for a year and a half, but during this time he was studied in various dermatologic offices and clinics from Florida to North Carolina. Several pathologists felt that the picture was definitely one of Kaposi's hemorrhagic sarcoma, while others felt that the picture was that of erythema elevatum diutinum. In May, 1949 he was carefully studied in the Duke University Clinic. All laboratory studies were reported within normal limits. Biopsies taken at this time were again viewed with much disparity of opinion. During this period treatment included several full series of penicillin injections, several courses of fever therapy, and two weeks of ACTH in doses of 100 mgm. daily, all without any demonstrable improvement.

On October 30, 1950 the patient was admitted through the Medical College Cancer Clinic to Roper Hospital for further study. At this time, in addition to the lesions on the extremities, he was noted to have groups of maculo-papular, dull, brown-red annular lesions over the trunk. Hematologic studies were of interest in that he was found to have a 15% eosinophilia with a total leukocyte count of 6,600 per cu. mm. Urinalysis and serology were negative. X-rays of the chest, hands, and feet were essentially negative. Biopsies were taken of both an old lesion and one of recent origin, and again histologic differentiation between Kaposi's disease and erythema elevatum diutinum could not be made with certainty. An axillary lymph node was histologically normal. A tracer dose of 200 uc. of radioactive phosphorus (P^{32}) was given

and showed fairly good localization in the lesions. However, the decision was made at this time not to give a therapeutic dose of the radioactive material and the patient was discharged, to be followed in the Cancer Clinic. He was subsequently given chloromycetin for two weeks, but tolerated the drug poorly and received no benefit from it.

He was not seen again at the Cancer Clinic for about one year. In October, 1951 he was presented at the meeting of the Baltimore-Washington Dermatological Association where erythema elevatum diutinum was accepted as the most likely diagnosis. In November, 1951 the patient was brought back to the Cancer Clinic for admission to Roper Hospital for the specific purpose of study and therapy with radioactive phosphorus. At this time the patient complained of extreme sensitiveness to cold and wore gloves for protection. Hemogram was normal, with no eosinophilia. Both an elevated and a flat lesion were excised for histologic study.

All pathologic material was reviewed and certain persistent histologic changes were found in all the biopsies which were most fitting to erythema elevatum diutinum. These consisted of nodular accumulations of hyperplastic blood vessels surrounded and infiltrated by inflammatory cells in which polymorphonuclear leukocytes were predominant (Figure 1). The vessels, although of capillary and arteriolar size, had conspicuously thickened walls due to splitting or re-

duplication of their collagenous fibrillae and marked swelling of their endothelial cell linings. (Figure 2). Polymorphonuclear leukocytes were often present at all depths within the vessel walls and degenerative changes with early necrosis could occasionally be detected. Eosinophiles were sparsely scattered through all sections.

The close proximity and actual infiltration of the proliferating vascular channels by polymorphonuclear leukocytes is often considered typical of erythema elevatum diutinum.^{4,5,6} This is certainly an outstanding feature in the case herein presented. The absence of any depositions of blood pigment, the thickness of the walls of blood vessels and the absence of any true neoplastic type of vascular proliferation all speak against Kaposi's sarcoma.

A tracer dose of radioactive phosphorus (P^{32}) again showed selective absorption by the lesions and therefore a therapeutic dose of 6 mc. of P^{32} was given on November 17, 1951. Biopsies taken two days after administration of P^{32} were studied by radioautographic techniques but provided no further information as to the nature of the lesion. After discharge the patient was followed by his family physician with frequent hematologic studies and showed no evidence of bone marrow depression.

On January 3, 1952, approximately seven weeks after administration of the radioactive phosphorus,



FIGURE I

Nodular accumulations of hyperplastic blood vessels within the dermis which are extensively infiltrated by polymorphonuclear leukocytes. Hematoxylin and eosin, X150.

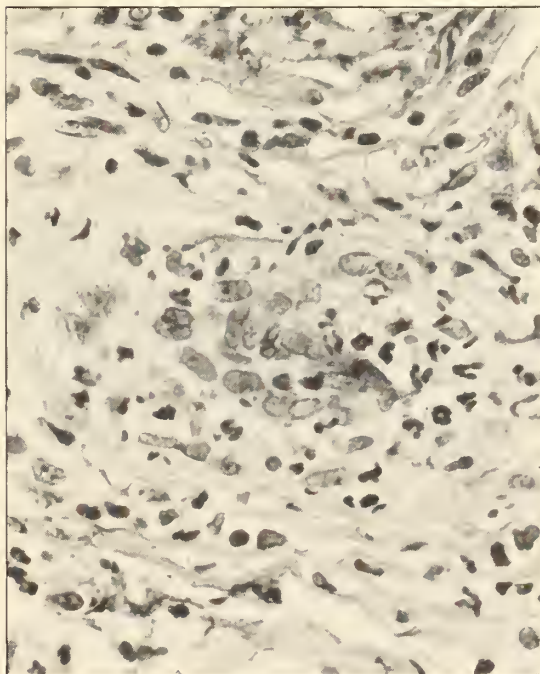


FIGURE II

Blood vessel showing swollen endothelial cells, degenerative changes in its wall and infiltration by leukocytes. Hematoxylin and eosin, X650.



FIGURE III

the patient returned to the Cancer Clinic stating that two weeks previously he had developed burning epigastric pain and ten days previously had vomited flecks of blood. He had noted an icteric tint to his skin at that time and thereafter his urine had become dark and his stools light in color. Examination on January 3, 1952 showed the patient to be moderately icteric. The liver was enlarged 3 cm. below the right costal margin and was tender. Rectal examination revealed clay-colored feces which gave a negative test for bile. Radioactivity counts showed definite retention

of radioactive phosphorus in the lesions, even after seven weeks, with at least a 2:1 differential between counts obtained over lesions and those obtained over normal skin. A gastro-intestinal x-ray series showed a small duodenal ulcer. It was felt that the patient also had either acute hepatitis or obstructive jaundice from inflammatory reaction associated with his ulcer, and therefore he was admitted to the Roper Hospital for treatment. Laboratory studies on admission: RBC 4.86 million; hemoglobin 14 gm.; WBC 5,300; differential count—PMN's 36, lymphocytes 53, eosinophiles 8,

monocytes 3; serum bilirubin 1.2 mgm. %; cephalin flocculation 3 plus; prothrombin concentration 82% of normal.

In the hospital the patient was placed on a modified ulcer regime, and improved symptomatically. His jaundice gradually subsided and liver function tests indicated a return to fairly normal function. A gastrointestinal x-ray series on January 22 showed healing of the duodenal ulcer. The possibility that his jaundice was due to hepatitis from the toxic effects of radioactive phosphorus was entertained but could not be proved. The patient's skin lesions showed no improvement with radioactive isotope therapy. Sensitivity to cold was marked, and the patient required heating pads for relief. The possibility of simultaneous existence of both Kaposi's disease and erythema elevatum diutinum was considered at this time.

The patient was discharged from the hospital on January 31, 1952 on a convalescent ulcer regime, and was seen in the Cancer Clinic one month later, at which time there was no evidence of jaundice, and liver function was good as determined by absence of bromsulphthalein retention. His liver was still slightly enlarged but was not tender. His cutaneous lesions remained unchanged.

He returned for admission to the Roper Hospital on May 29, 1952 for a trial of therapy with hydrocortisone (Compound F). The appearance of the lesions at this time is depicted in Figures 3-5. The symmetrical distribution of the lesions, characteristic of erythema elevatum diutinum, is clearly shown in



FIGURE V

Figure 3. Figure 4 illustrates, in a close-up view of the buttocks, the flat, macular type of lesion, while Figure 5 shows the elevated lesions present on the hands.

Hydrocortisone, 2.5 mgm. in 0.1 cc. of solution, mixed with an equal volume of 1% procaine hydrochloride, was injected into and around each of eight lesions on the hands and feet. Temporary pain resulted, but was not incapacitating. When seen one week later, there was no demonstrable change in the lesions, but the follow-up period is, of course, too short to permit proper evaluation of the results.

SUMMARY AND COMMENT

A case has been reported which exhibits characteristics of both Kaposi's hemorrhagic sarcoma and erythema elevatum diutinum but which is now believed to represent the latter condition. At the time of publication the patient continues with his disease unchanged by all efforts at therapy. Rutin, vitamin C, various antibiotics, fever therapy, ACTH and radioactive phosphorus have failed to influence the disease in any noticeable manner. Hydrocortisone (Compound F), given by local injection into the lesions, has produced no immediate improvement, but full evaluation of the effect of this agent must await a longer follow-up period.

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FIGURE IV

The Journal of the South Carolina Medical Association

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Florence, S. C.

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 JULY, 1952

N. B. HEYWARD

On June 3, 1952, death came to Dr. Barney Heyward in a manner as he would have wished it, swiftly, without warning and in the midst of vibrant energetic living. With his passing there ends a career of medical service to mankind, professional fellowship, and gracious living that reached heights obtained by few.

Following graduation from medical school at the College of Physicians and Surgeons in New York City, in 1913, Dr. Heyward began the practice of medicine in Columbia, the city of his birth. For thirty-nine uninterrupted years he continued this practice in the field of internal medicine.

To the medical profession he was an accepted leader, with clear thinking and considered judgment; to his patients he was not only a medical advisor, but a true friend with a rare capacity for tact and understanding.

He served medicine not only as an able practitioner but in several associated ways as well. As a member of South Carolina State Board of Medical Examiners for twenty-five years and as secretary to this Board for nine years, through his untiring efforts in this difficult position, the work of selecting proper physicians for South Carolina developed into a smoothly functioning efficient system. Hundreds of South Carolina doctors will remember his kindly advice while taking the State Board Examinations.

In organized medicine also, Dr. Heyward was an outstanding figure. He was intensely interested in the activities of the Columbia Medical Society of which he was president in 1923. As secretary of the South Carolina Medical Association during the last two years of his life he worked constantly for what he felt was in the best interests of his fellow physicians.

But Dr. Barney lived no narrow life of medicine alone. A friend of his once said, "he is one of the few men with the ability and sense to live life as it should be done." He was a devoted husband, father, and grandfather who insisted that nothing should intrude on his opportunities for spending time in a happy family circle, loving and living together as should be.

Athletics too shared in the many interests of his life. First as a participant on a University of South Carolina* football team, for a number of years as University of South Carolina and team physician, later as an ardent supporter and spectator. As was the spirit and nature of the man, all athletic efforts deeply interested him, particularly football and boxing at the University of South Carolina. It could almost be said that nothing would keep him from one of these contests were it not for another interest which at times superceded all other considerations, hunting and especially swamp hunting.

"Doves in a brisk wind—grand,

Birds behind good dogs—elegant,

Ducks at dawn—wonderful,

But turkey hunting—why man, that's postgraduate hunting!"

With boundless energy and ever eager enthusiasm Dr. Barney was one of the truly great hunters of all time.

An excellent doctor, a loving father, a charming gentlemen, a perfect friend, and a real man—surely this world needs more men like Barney Heyward.

W. C. C.

A. M. A. HOUSE OF DELEGATES

Several matters evoked considerable discussion at the recent meeting of the House of Delegates of the A. M. A. in Chicago and important decisions were made, decisions whose impact will be felt for years to come.

The President's Commission on the Health Needs of the Nation. Without dealing with any personalities, the House of Delegates endorsed the opinion of the Board of Trustees and of its officers that "there is adequate evidence to establish that it was created for the purpose of removing a very troublesome issue from public consideration during an election year." The House of Delegates backed up the Board of Trustees in its denouncement of the political purposes which lie back of the Commission's work.

Osteopaths. The problem of osteopaths is becoming acute in many sections of the country, particularly in those rural areas of certain states where up to 25%

of the medical care is being rendered by these individuals. The day before the House of Delegates met, newspapers carried the story of the difficulties which had arisen in Bay City, Michigan, where the City Council, faced with a petition signed by 5,000 citizens, had ordered the wards and private rooms of the city hospital made available to the patients of osteopaths. As a result, doctors of medicine were moving their patients to another hospital.

The ideas and opinions presented on this problem were varied. At the one extreme were those who thought every effort should be made to elevate osteopaths to a place where they would be eligible to attain the status of doctors of medicine. At the other extreme were those who advocated having nothing whatever to do with the cultists.

It was a problem too difficult to solve with information at hand and a special committee was appointed to study the whole matter and to report back to a subsequent meeting of the House.

Social Security Benefits. On May 19, the Ways and Means Committee of the U. S. House of Representatives introduced an omnibus bill with regard to Social Security benefits. Section 3 dealt with a phase of permanent disability and spelled out detailed powers of administration for the Social Security Administrator. An effort was made to introduce this under a suspension of the rules which would have done away with the possibility of hearings. Through the efforts of the American Medical Association and others, this was defeated. During the meeting of the House of Delegates information was received that the Bill would again be introduced with the specific powers of the Administrator deleted, but with power left with him to set up the rules of administration.

The House of Delegates adopted a strong resolution condemning "the breach of faith by this Administration with those who would benefit from this Bill in a flagrant attempt to railroad through a provision to aid in the socialization of medicine, which would not possibly be adopted if considered openly and fairly," and urged that "Congress refer this Bill to the Committee where it should be subject to the ordinary Democratic processes of legislation."

Subsequent events have shown that this resolution failed in its purpose and the Bill was passed by the House of Representatives on June 18.

Negro physicians. A resolution was introduced by the delegates from N. C. asking that the North State Medical Society (which is composed of physicians, dentists, and pharmacists) be recognized as an affiliate society of the N. C. Medical Society and of the A. M. A. The resolution was not adopted on the grounds that it was not constitutional. It was further brought out in the general discussion that the question of negro physicians gaining membership in county and state societies was one which had to be worked

out at the local level. The plan which we adopted here in S. C. was discussed and highly commended.

New officers. Dr. Louis Bauer of New York was installed as President and his inaugural address, which was carried by two radio networks, was a dynamic and fighting speech. Dr. Ed. McCormick, a surgeon of Toledo, was selected as President-elect, winning out over Dr. Frank Borzell. Dr. James Reuling of New York was elevated to the position of Speaker of the House of Delegates, and Dr. Vincent Askey of San Francisco was chosen as Vice-speaker.

Future meetings. The annual sessions (June) will be held as follows; 1953—New York, 1954—San Francisco, 1955—Atlantic City. The interim session (December)—1952—Denver, 1953—St. Louis.

JOHN CLINE SPEAKS

At the opening session of the House of Delegates of the American Medical Association, the retiring president, Dr. John Cline, delivered his address. It was a comprehensive and masterful presentation of the observations which he had made while in office.

We present herewith some of the striking statements in his speech. They should be of interest to all, but particularly to those who were privileged to meet and hear Dr. Cline when he visited in South Carolina last year and appeared before physicians in Columbia, Greenville, and the Pee Dee.

ADDRESS OF THE PRESIDENT

JOHN W. CLINE, M. D.

To the House of Delegates

June 9, 1952

The past year has been busy and somewhat strenuous for your President. It has carried me to many states and all parts of the country.

It has been gratifying to observe the growing unity and increasing vigor of the profession. The degree varies in the different states but the trend is apparent everywhere.

The past year represents one of great achievement in medicine. There have been important additions to our scientific knowledge and we have learned to reduce farther the latent period between the establishment of scientific fact and its practical application in diagnosis and treatment. Rapid dissemination of information by means of meetings and publications and the increased cooperative effort by investigators in common and differing fields have contributed to this process. Scientific medicine now is coordinated to a degree never previously attained.

Medical education at all levels—undergraduate, graduate and postgraduate — has continued to improve. Graduate education has suffered to some degree as a result of defense mobilization and we must plan now to provide opportunity for those in the Armed Forces to complete their training when returned to civilian life.

Perhaps the most significant advance is to be found in the field of postgraduate education. More planned postgraduate courses have been offered and, in some instances, these have been carried to the physician in his home community. The attendance at meetings which have been better organized and of high quality, has increased.

Medical care has increased in quantity as well as in standards. The American people enjoy more abundant and better medical care than ever before.

The ratio of physicians to population has increased and there is better distribution of doctors. Improved transportation, better facilities and greater use of auxiliary personnel have permitted the physician to make better use of his time and render better care to more people over a wider area.

The interest of medical students in general practice and in rural practice has been fostered by the medical schools, the state associations and the American Medical Association. These efforts coupled with the placement agencies of our state and national organizations and the increased assumption of responsibility by local communities for providing medical care, have resulted in placing many physicians in areas in need of their services.

Until comparatively recently inducing physicians to locate in places needing them was considered to be solely the responsibility of the profession. It now has been demonstrated that young, well-trained physicians will go readily to communities in which they are able to practice medicine of the high quality learned during their medical school and hospital years. They will remain if the community will avail itself of their services throughout the year and if living conditions and educational facilities are adequate to provide satisfactory surroundings in which to raise a family.

There are abundant examples of success in obtaining and holding physicians when the community undertakes its portion of the burden of improving the facilities for practice and providing adequate educational opportunities for children. These serve to focus attention upon certain essential aspects of community life.

Plans for protection against the costs of illness have grown and improved during the past year. More than 85,000,000 Americans now have Blue Cross or other hospital coverage, 65,000,000 have surgical and 28,000,000 medical and surgical protection.

During the year, additional millions of Americans have enrolled in these programs, demonstrating that American problems can be solved by American methods and far more successfully than by resorting to government for a partial solution restricted within the rigid framework of legislation.

The multiplicity and elasticity of our plans stimulates experimentation and encourages the orderly pro-

cess of evolution. This ultimately will provide us with a plan or plans which will be generally recognized as the most nearly ideal for our people.

The plans for prepayment have undergone considerable development in the past year. Coverage against economically catastrophic illness has become more general. Individual coverage is more available and experiments in covering the aged are under way. The rural population has wider protection. More must and will be done in these areas as time passes. Caps have existed and some still exist but these are being closed.

Over the country one finds variation in the interest of the profession and the backing it gives to the voluntary insurance program. On the whole it is good and is improving.

The voluntary plans fill a great need and render a great service to our people. On this basis alone they deserve our full support. Unquestionably they are far from perfect and defects exist in some plans. Where changes are needed let us strive to bring them about in a constructive fashion.

Destructive criticism and withholding support and cooperation interfere with proper development and damage the entire program. Injury to the voluntary movement would jeopardize our future freedom.

Opinion is almost unanimous that a strong and successful voluntary insurance program is our greatest bulwark against the socialization of medicine. This opinion is held by many of our friends in other fields of endeavor and in public life. It is shared by those who would destroy the high standards of American medicine by placing it under bureaucratic domination. Some of these belittle the accomplishments of the program and some have tried to interfere with its development because they realize that it stands as a barrier against the accomplishment of political medicine.

We have recognized and accepted our responsibilities to provide the American people with medical care of continuously improving quality and to make that care more easily available to all. We must continue our efforts.

On the other hand, there is also growing recognition of a coexistent responsibility on the part of the public. It has been said that the plans for extension of medical care are solely the responsibility of the medical profession. It is essential that the public, the plans and the hospitals assume their portions of the burden. The provision of medical care is not a one-way street and others must meet their obligations as well.

In the course of twenty years of dealing with medical problems on the local, state and national planes, I have watched these problems multiply and become more complex at all levels. As medical care and health have become more prominent in the minds of the people this change has been inevitable. As public interest has increased in these matters, we have come more closely under public scrutiny. As medical affairs have become more important our relations with other

groups have become more important and the operations of the American Medical Association have become more important.

These activities have been strengthened in many ways. A large number of individuals have been responsible. They are too numerous even to mention at this time although I have drawn attention to some of their activities during the year through the medium of the President's Page. The headquarters staff consists of almost nine hundred loyal, hard-working employees distributed in twenty departments. With the exception of the purely organizational departments, all are working full time directly or indirectly in the public interest.

I cannot allow this opportunity to pass without paying my respects to our calm, efficient and extremely able Secretary and General Manager, Dr. Lull, and to his very capable, energetic and loyal assistant, Dr. Howard, who direct the staff. During the past year numerous changes have been made in the interests of more efficient operations.

The quality of The Journal has continued to improve under the admirable direction of the Editor, Dr. Austin Smith. In my travels about the country I have heard many compliments, few criticisms of The Journal and almost unanimous approval of the changes he has instituted. J. A. M. A. has increasingly justified its reputation as the most highly respected and most widely read medical journal in the world.

The Board of Trustees is composed of fine, sincere and able men who labor arduously and with serious purposes dealing with the many matters demanding their attention. As the problems of medicine have multiplied the agendas have increased in length. It is only by close application to its work, under the capable and efficient direction of its splendid and devoted Chairman, Dr. Murray, that it is able to perform the many tasks assigned to it. I wish to express my deep appreciation to the Board and its Chairman for the excellent record of accomplishment of the past year.

To you, the members of the House of Delegates, I wish to express my compliments and my appreciation of the character of your deliberations. In your meetings you have considered and debated many matters. The serious responsibility of determining the basic policies of American medicine is yours. The decisions you make and the methods of expressing them are of great importance. The thought, diligence and care you have devoted to your transactions have clarified the position of medicine and have built well for the profession.

During the past year more attention has been paid to the relationship of medicine to other professions. The association with other groups concerned with the care of the sick has become closer. Problems still exist in certain areas of contact but progress has

been made and is being made in dealing with them. Some will require long periods for complete solution.

No problem is too difficult to solve if patient men of good will approach it in a spirit of cooperation. An excellent example is the successful conclusion of the negotiations in the establishment of the Joint Commission on Hospital Accreditation.

The medical profession and the hospitals are interdependent. What affects one affects the other. There is growing concern over mounting hospital costs and the hospitals have been unduly criticised because of them. We can do much to dispel misconceptions by explaining to our patients the reasons for this situation. About 65 per cent of hospital costs are attributable to salaries and wages. As scales of compensation have risen, costs have risen correspondingly. In addition every item which the hospital must purchase is more expensive due to the spiral of inflation which involves our entire economy.

On the other hand, certain hospitals continue to engage in the practice of medicine in defiance of established principles and in contravention of the law in most states. There is, I believe, widening recognition by hospitals that the practice of medicine is the practice of medicine whether performed within or without the hospital. We recognize the right and the necessity for hospitals to derive income from certain departments staffed by physicians and ethical arrangements have been worked out whereby the rights of all concerned are respected. The hospital must not become dominant in the practice of medicine. This appears to be the objective of a small minority of administrators and trustees.

The curricula of modern osteopathic schools now are patterned largely after those of schools of medicine. The level of education provided by some has improved since the conclusion of the last war. There have been recent discussions between a committee of our Board and a similar group of the American Osteopathic Association. The representatives of the osteopathic profession express a desire for our assistance in further improving the education of students in osteopathic schools. In thirty-odd states the licenses granted to osteopathic physicians approach or approximate, for practical, legal purposes, those granted to doctors of medicine. We cannot accept or recognize the basic concept of osteopathy as a valid method of treatment of disease. The osteopathic profession apparently appreciates that fact as evidenced by the progressive reduction of the emphasis upon the teaching of osteopathy in favor of instructions in medicine and surgery. Removal of the stigma of cultism would hasten that process.

It is my considered opinion that the Council on Medical Education and Hospitals should be permitted to aid and advise schools of osteopathy and that we should facilitate the opportunities of these schools to

improve their faculties by removing any barrier of unethical conduct on the part of doctors of medicine who may teach in these schools. I recommend that the House take action to implement these suggestions.

We must continue to strive for greater cooperation between medicine and the dental, nursing and pharmaceutical professions. Closer relationship will work to the advantage of all.

The public relations of medicine have improved but much remains to be done. In one sense, the esteem in which medicine is held by the public is the total of the patient-physician relationships of the entire country. The good deeds of the ninety-five per cent or more of the profession go unnoticed and are taken for granted. The transgressions of a very small proportion of physicians do untold harm to the entire profession.

Our Code of Ethics is not a body of law but is a pattern for conduct. In a sense it is the code of the gentleman in the practice of medicine. Even if it did not exist it would not be violated by many because the vast majority of our members are gentlemen.

We have long recognized and subscribed to the dual obligation of the physician to his patient: To render to the patient the best possible medical care and to deal fairly with him in all ways. Unfortunately there are a few of our colleagues who do not respect these obligations.

When these are encountered they must be thrust from the company of gentlemen. There can be no compromise with dishonesty or unethical conduct. We owe forthright action not only to the public but to ourselves. Respect, to be maintained, must be deserved.

Grievance committees have gone a long way in improving the situation but the mere existence of such committees is not enough. They must be composed of physicians who are respected, not only for their professional attainments but, also, for their character, impartiality and courage. These committees must be active, easily available and the public must be informed of them and the means of access to them.

These provisions will do much to inspire public confidence. The work of these committees can be greatly reduced if the physician will discuss all aspects of his services to the patient at the outset of his contact with him. This procedure will reduce misunderstandings to a minimum and since most complaints against the profession are based upon misunderstanding these will be greatly lessened.

There also has been a great change in the public position of medicine. Medicine and the American Medical Association had been subjected to years of the most vicious, systematized campaign of vilification

ever waged against a respectable profession and organization devoted to the public interest. We were not prepared to meet these onslaughts. You all recall vividly the situations which confronted us in December 1948.

Conditions have changed. We are stronger, more unified and are better able to prevent the destruction of the high standards of medical care inevitable in socialistic schemes of its administration. Medicine has become a significant force in American life.

The vigorous support of physicians and others throughout the country who perceived the danger to the future quality of medical care has brought about this transformation. This activity stemmed largely from the National Education Campaign so ably directed by Clem Whitaker and Leone Baxter. They deserve great credit for their splendid performance in the face of many difficulties. I wish to express the gratitude of American medicine and my own personal thanks to them for an important job well done.

When one thinks back over the period of three and one half years and observes the change, he cannot help but be impressed. In that short time medicine has changed from an ideal whipping boy for any demagogue who wished to make a rabble rousing speech into a strong body able to respond with sufficient vigor and effectiveness to make the profession an unwise object to attack.

In the long view an even greater contribution, perhaps, has been the insistence that we meet the problems confronting medicine on a positive, constructive basis and that the Association develop a strong public relations department of its own to deal with matters of fundamental importance now and in the years to come. I have described the department and its operations in a President's Page and believe it to be growing in effectiveness.

As a result of our efforts and the increasing strength of medicine, those who would destroy our capacity to render the best care to the American people have altered their strategy. As far back as the 81st Congress it was apparent that no all-inclusive bill for socialized medicine could be passed.

Our opponents realized this earlier than did we and altered their course correspondingly. They ceased the effort to overwhelm us by frontal attack and resorted to more subtle flanking maneuvers by concentrating upon the so-called fringe bills, the most important of which was federal aid to medical education. To date we have been successful in preventing legislation which would have placed the medical schools of this country in imminent danger of bureaucratic control.

We recognize that our medical schools are in financial distress and we are making an effort to alleviate this situation through the American Medical

Education Foundation and the National Fund for Medical Education. The results to date, this year, are more encouraging than in the first year. Every one of us owes a great debt to medical education and it must have our fullest support. Medical education is every doctor's business.

Another manifestation of the recognition of changed conditions has been the politically inspired appointment of the President's Commission on the Health Needs of the Nation. There is adequate evidence to establish that it was created for the purpose of removing a very troublesome issue from public consideration during an election year. This course of action was predicted by a competent observer months in advance and we now have sufficient information of the immediately preceding events to know this to be the case.

Doubt remaining in the mind of anyone concerning the political motives behind the creation of the Commission should have been dispelled by the President's recent unwarranted, undignified and intemperate attack upon the American Medical Association. It is apparent that the Administration's intention to socialize medicine has undergone no change. It is obvious that it will resort to parliamentary legerdemain to accomplish what cannot be achieved by more direct and honest methods. The angry petulance of the outburst provoked by the Association's exposure of the political trickery reveals the true colors of the Administration.

The Commission was assigned an impossible task to perform within the period of time allotted and has been described as an organization whose principal accomplishment would be to survey all pre-existing surveys to decide if additional surveys were needed. I have discussed the appointment of this body at length elsewhere.

The Board of Trustees was unanimous in denouncing its creation and the political purposes behind it. Primarily out of deference to the chairman of the Commission, the American Medical Association has made the information in its possession available to the Commission and authorized officers and employees to testify before it while completely and thoroughly disapproving of its appointment.

After such testimony has been given, by participation in panel discussions, agents of the Commission have made purported digests of the testimony. In certain instances these have ignored completely most of the statements made to the Commission. Participants have then been requested to approve or amend the distorted digests. To amend the statements adequately would require days of effort in addition to the time occupied by travelling to and from Washington and testifying. The digests have the appearance of pre-

conceived editorialized opinions of the person or persons preparing the abstracts and do not report fairly the points of view presented to the Commission. It is obvious that this procedure is not compatible with fair presentation of the facts. I bring this situation to the attention of the House to the end that it may be able better to evaluate the ultimate report.

In view of the magnitude of the task, the limited facilities and the short period of operation—characterized by the Commission Chairman as "too big a job for one year" any report emanating from it must be carefully examined. It will not only be based upon inadequate time and opportunity for study but may have all the misleading and dangerous attributes of a snap diagnosis. The report may be voluminous and impressive in appearance but probably will reflect the preconceived ideas of a majority of the Commission. It must be scrutinized with great care.

Let us not be misled by the apparent quiet of the moment. Our battle is not yet won. Complacency could well be a fatal error. I recall clearly the false security of 1946 at which time it was said that socialized medicine was "as dead as a dodo." Two years later American medicine confronted the gravest crisis in its history. There also are important external threats as will be detailed to you by Dr. Bauer.

Few persons realize the distance we have travelled, as a nation, down the road to socialism. As physicians we know that in the course of many diseases a point is reached where the changes of structure in the tissues become irreversible and restitution of normal function becomes impossible. The disease of socialism which affects our body politic is at the present time not far from that point.

This may well be the year of decision. Unless the trend toward an all powerful government progressively extending its influence into our daily lives, limiting our horizons and sapping our initiative is halted, the changes in our political, economic and social structure will soon have reached the state of irreversibility. If this occurs we will have sacrificed the most precious heritage any nation ever had, and for a mess of socialistic pottage.

Medicine's firm stand has encouraged others to resist this process. At the present time we have more and stronger allies than ever before.

I urge every citizen who values the American tradition of freedom, opportunity and dignity of the individual to utmost effort this year. This may be our last chance to preserve those essential ingredients of American life.

Our leadership has inspired others. We have a great responsibility and a great opportunity. Let us not be in default.

DEATHS

WILLIAM ADAMS CARRIGAN

Dr. W. A. Carrigan, 76, of Society Hill, died on June 5th, after an illness of several months.

A native of Society Hill, Dr. Carrigan received his medical education at the University of Maryland (Class of 1902). Following his graduation he returned to his home community where he engaged in general practice for twenty-eight years. In 1930 he became Darlington County Health Officer and held this position in 1950.

Dr. Carrigan was a faithful attendant upon medical meetings and served as secretary of the Darlington County Medical Society for a period of years.

He is survived by his widow, the former Miss Beulah Womack and two daughters, Mrs. W. B. Hodges of Asheville, and Mrs. Lawson Nolan of Society Hill.

FREDERICK CANNON BRINKLEY

Dr. F. C. Brinkley, 62, died on June 11th of cardiac disease.

A native of Aiken County, Dr. Brinkley received his education at the University of Georgia School of Medicine (Class of 1910). Following graduation he began the practice of medicine in Ellenton which continued until his retirement several months ago.

In addition to an extensive medical practice Dr. Brinkley was active in civic and political circles. He was mayor of Ellenton for several years and received national publicity as such when the South Carolina II Plant forced evacuation of the town. Dr. Brinkley also served eight years as Senator from Aiken County, was a member of the South Carolina Highway Commission for two years, served as a member of the Savannah River Navigation Commission, and was a delegate to the National Democratic Convention in 1936 and 1940.

Dr. Brinkley is survived by his widow, the former Miss Lilly Owens of Dunbarton, and three daughters.

EDMOND J. BRYSON

Dr. E. J. Bryson, 66, died in Liberty, May 29.

A native of North Carolina, Dr. Bryson received his medical degree from Loyola University Medical School and followed this with post-graduate study at Charleston, New York, and Chicago.

Following graduation, he entered military service during World War I and spent most of his time at Camp Jackson. In 1915, he entered practice in North Carolina.

In 1925 Dr. Bryson opened an office for practice in Liberty where he worked for about twenty years. During this time he not only carried on an extensive practice, but was also active in civic affairs, serving as Mayor of the town for 11 years. Subsequently, he moved to Greenville and then to Asheville where he devoted most of his activities to work with alcoholics.

Dr. Bryson is survived by his wife, the former Miss Mabel Klepper, and two daughters.

NEWS ITEMS

Dr. Walter R. Mead, Florence physician and civic leader, was the recipient recently of the "Man of the Year" civic service award, sponsored annually by the

Rotary, Kiwanis, Optimist, Lions and Exchange Clubs of Florence.

Dr. Orin R. Yost, Medical Director of the Edgewood Sanitarium at Orangeburg, attended a meeting of the American Psychiatric Association, held recently in Atlantic City.

Dr. William P. Turner of Greenwood has been appointed to the State Board of Medical Examiners to replace Dr. C. H. Blake of Greenwood. Dr. Wynian King of Batesburg will replace Dr. J. D. Parker of Greenville on the State Board of Examination and Registration of Nurses.

Dr. O. A. Alexander of Darlington has returned to private practice and is associated with Dr. A. P. Rosenfeld. Dr. Alexander became County Health Officer of Darlington County in 1950.

Dr. E. B. Michaux, Dr. S. C. Black and Dr. Tom Hankins, all of Dillon, were guests of the Eli Lilly Company May 21 to May 24 in Indianapolis, Ind.

Dr. B. J. Workman of Woodruff has been appointed to the State Advisory Hospital Council for a four year term. He replaces Dr. M. R. Mobley of Florence.

Dr. W. McNeill Carpenter is re-opening his office in Greenville, his practice being limited to eye, ear, nose and throat work.

Attending the American Academy of Pediatrics in Washington recently were Drs. J. I. Waring, B. O. Ravenel, and Bachman S. Smith of Charleston, Dr. Walter Moore Hart of Florence.

Dr. D. J. Greiner, a graduate of the University of Pittsburgh, has been appointed Director of the Department of Pathology at the McLeod Infirmary in Florence.

CORRESPONDENCE

Dr. Julian P. Price, Editor
The Journal of the
South Carolina Medical Association
Florence, South Carolina

Dear Julian:

Dr. John Douglass, immediate past-president of the South Carolina Dental Association, asked me to ask you to publish the following:

Senator Burnet R. Maybank has been working actively to bring about an extension of the law which allows payment of \$100 over and above the ordinary rank pay to all dental and medical officers in the United States Armed Forces. The following telegram was received from Senator Maybank early in June:

"We passed the continuing bill to pay the dentists and physicians. Please advise our friends." /s/ Burnet R. Maybank.

It gives me pleasure to pass this on to you for John Douglass, who worked with us actively in our efforts to bring about a reorganization of the State Board of Health.

With kind regards and best wishes, I am

Sincerely yours,

J. Decherd Guess, M. D.

THE TEN POINT PROGRAM

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

GRIEVANCE COMMITTEE ORGANIZED

The newly created Grievance Committee of the South Carolina Medical Association held its first meeting on June 9, 1952 and organized with election of the following officers: Dr. Roderick Macdonald, Chairman; Dr. Weston Cook, Vice-Chairman; Dr. J. A. Siegling, Secretary.

The Committee adopted for its guidance in discharging the duties delegated to it by the House of Delegates, the Rules which had been previously endorsed by Council, and which were published in the Journal of the South Carolina Medical Association in August, 1951. It directed that the creation, organization and general purposes of the Committee be fully publicized.

Dr. Cook, Vice-Chairman, reported to Council at its meeting on June 10, the progress of the Grievance Committee thus far, and its plans were approved.

BLUE CROSS AND BLUE SHIELD OFFER NON-GROUP ENROLLMENT

Blue Cross and Blue Shield will offer non-group membership during the month of August. The non-group enrollment will be state-wide, and will be offered to anyone under the age of 65, regardless of place of employment and without the usual group requirements. Applicants may enroll on an individual or family contract, but married women must enroll on a family contract and both husband and wife must be under the age of 65.

This type of Blue Cross-Blue Shield enrollment comes but once a year. It offers an opportunity to thousands of people who have shown interest in Blue Cross and Blue Shield, but who have not been eligible for membership because of the usual group quota requirements. The enrollment will close on the last day of August, and protection will begin on September 15.

Informational literature and applications are being sent to all member hospitals and all doctors in the State. Completed applications should be returned to any area office of Blue Cross and Blue Shield with the required quarterly payment in advance.

This year, Blue Shield will have additional coverage to offer in the medical benefits that will be effective August 1. A subscriber may apply for either the Blue Shield Surgical Plan, or the Surgical-Medical Plan at the slightly higher rates. Benefits and rates are fully explained in the informational literature.

The August non-group enrollment affords the doctor an opportunity to acquaint his patients with the excellent coverage and protection offered by Blue Cross and Blue Shield. These two Plans are pro-

moting a program of better health protection for everyone, and financial security in the event of illness or emergency. As the cost of hospital and medical care has spiralled, the Plans have made every effort to keep step with the trend, and to provide the best of care for their members at the lowest possible cost.

BLUE SHIELD CONTINUES TO GROW

The South Carolina Blue Shield Plan continues a steady, substantial growth. The following Enrollment Report for the month of May shows by comparison the extent of its growth during an average thirty days period.

We understand that these figures do not include a substantial number of the employees at the DuPont plants, whose contracts have become effective since the report was made up.

The last meeting of the Board of Directors was the occasion for election of officers for the year (the first meeting following the Annual Meeting of the South Carolina Medical Association). All of the officers were reelected, as follows: President—J. D. Guess, M. D., Vice-President—M. L. Meadors, Secretary—George D. Johnson, M. D., Treasurer—J. D. Ashmore.

The current healthy financial situation of the Plan is reflected in its balance sheet, as of May 31st, 1952, which follows the Enrollment Report below.

SOUTH CAROLINA MEDICAL CARE PLAN ENROLLMENT REPORT

Month of May, 1952

	Employed	Subscribers	Dependents	Total
Membership at end of preceding month	----	16508	27173	43681
New Enrollment—Current Month	-----	1035	1800	2835
Cancellations—Current Month	-----	241	363	604
Net Enrollment—End of Current Month	-----	17302	28610	45912

Balance Sheet as of May 31, 1952

ASSETS			
CASH IN BANKS			
General Fund			
Account	\$68,570.98		
Physicians Claims			
Account	17,113.25	\$85,684.23	

ACCOUNTS RECEIVABLE

Due From Blue Cross Plan	\$31,986.50	
Subscriber Payments	3,641.06	35,627.56

FURNITURE AND EQUIPMENT

Purchase Price	\$ 78.40	
Less: Res. For Depreciation	16.28	
Net Book Value		62.12

TOTAL ASSETS	\$121,373.91
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LIABILITIES, RESERVES AND CAPITAL

ACCOUNTS PAYABLE

Due To Blue Cross Plan	\$ 7,306.21	\$ 7,306.21
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DEFERRED INCOME

Unearned Sub. Charges	\$18,200.38	
Subs. Charges Paid in Advance	48.95	18,249.33

RESERVES

Reserve For Unpaid Claims	\$20,568.37	20,568.37
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CAPITAL AND SURPLUS

Donated Capital	\$10,250.00	
Surplus	65,000.00	75,250.00

TOTAL LIABILITIES, RESERVES AND CAPITAL	\$121,373.91
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FURTHER DEVELOPMENTS WITH HR 7800

In this column last month we discussed at some length the action of the National House of Representatives with respect to H.R. 7800, the bill to provide certain amendments to the Social Security Law. It will be recalled that on May 19, a motion to suspend the rules and pass the bill was defeated through failure to attain the necessary two-thirds majority, although an actual majority of the votes were in favor of the motion.

The advocates of the measure, including Section 3, to which the medical profession objects, were not satisfied with the result of the vote on May 19, and continued their efforts. There were public statements

by the President, Mr. Ewing, and certain officials of the American Medical Association. On June 12, in the final session of the House of Delegates in Chicago, the following resolution was adopted, after some discussion:

WHEREAS, Congressman Doughton (D., N. C.) on May 12 introduced in the Congress an Omnibus Measure, H. R. 7800, 82nd Congress, providing for various amendments to Title II of the Social Security Act, which bill was reported favorably by the Ways and Means Committee of the House of Representatives on May 16 and brought before the House of Representatives on May 19 under a suspension of the rules; and

WHEREAS, Section 3 of this measure provided for the introduction of a new theory in the Social Security Program which in its implementation could result in the socialization of the medical profession inasmuch as it would provide that the Federal Security Administrator should (a) determine what constitutes permanent and total disability; (b) establish the types of proof necessary to establish permanent and total disability; (c) provide by regulation when and where physical examinations should be taken; (d) be authorized to prescribe the examining physician or agency (including federal installations); (e) establish the fees; (f) be authorized to pay travel expenses and subsistence incident to the taking of such physical examinations, and (g) have power to curtail Old Age and Survivors' Insurance benefits because of non-compliance with regulations of this section; and

WHEREAS, The American Medical Association strongly protested against its adoption without full and complete hearings with respect to the controversial provisions of Section 3 of the Bill; and

WHEREAS, Following the rejection of the Bill on May 19 by the House of Representatives, certain amendments were made to the Bill by the House Ways and Means Committee which purport to eliminate the objectionable features of Section 3, and

WHEREAS, Notwithstanding certain deletions from Section 3 the fundamental purpose of this Bill to extend the power and authority of the Federal Security Administrator remains unchanged, and the deletions which have been made are only another attempt to hoodwink the public into believing the section is completely altruistic; and

WHEREAS, The attempt is again being made to present this Bill to the House of Representatives next Monday (June 16) under a suspension of the rules; and

WHEREAS, The defeat of H. R. 7800, depriving Social Security beneficiaries of numerous additional benefits, was a direct result of the Truman Administration's attempt to play politics by tying in a Socialized Medicine scheme with an otherwise popular measure; therefore be it

Resolved, That the American Medical Association

condemns the breach of faith by this Administration with those who would benefit from this Bill in a flagrant attempt to railroad through a provision to aid in the socialization of medicine, which could not possibly be adopted if considered openly and fairly; and be it further

Resolved, That the American Medical Association urges that Congress refer this Bill to the Committee where it should be subject to the ordinary Democratic processes of legislation.

Despite the foregoing and efforts on the part of others opposed to the passage of Section 3, the House on June 16, adopted the motion and passed the bill by the necessary majority of two thirds. This reversal of its previous action was not particularly surprising in view of the strenuous, and in some respects, bitter campaign waged by the proponents of the bill between the dates of the two votings. It is not surprising particularly, in view of the fact that the measure provides additional sums (\$5.00 per month) for most of the beneficiaries of the old age and retirement provisions of the present Social Security Law. Nobody objects seriously to these provisions and certainly the medical profession has not directed its attack on the measure because of any opposition to this part of it. In an election year it is beyond reasonable expectation that such a measure would fail of passage. Section 3, providing extensive authority to the Federal Security Administrator in the determination of those entitled to total and permanent disability benefits, in the designation of the physicians who would conduct the necessary examinations, and in determining the extent and frequency of such examinations, was included in the measure for the very reason that it was a bill destined almost certainly for passage.

At the present writing, however, it still is not law. The Senate Committee on Finance, to which it was referred in that body, deleted the objectionable Section 3, and reported the bill favorably with that exception. At this writing, the measure is yet to come before the Senate for final action.

AIMS AND ACCOMPLISHMENTS OF THE WORLD MEDICAL ASSOCIATION*

Louis H. Bauer, M. D., F.A.C.P. Secretary-General

In the minds of many of my colleagues an understandable confusion exists between the World Medical Association (WMA) and the World Health Organization (WHO). To explain the difference very briefly, WHO is an official branch of the United Nations, representing the governments of the world in the field of medicine, whereas WMA represents the practicing physicians and national medical associations of the world. It is a non-governmental organization and its funds are received from membership dues and voluntary contributions.

*Reprinted from The Westchester Medical Bulletin, May 1952.

To clarify further just what the World Medical Association is and does, a little historical background

is needed. During World War II, doctors from all over the world frequented the Headquarters of the British Medical Association in London. They formed friendships and discovered that they had common problems. Ways and means were discussed of perpetuating these relationships. Several conferences were held and representatives of national medical associations formed an Organizing Committee. This Committee drafted a Constitution and By-Laws which were submitted to the First General Assembly at Paris. Official organization was effected in that city on September 18, 1947.

OBJECTIVES

The objectives of the Association as outlined in the Constitution are:

- (1) To promote closer ties among the national medical organizations and among the doctors of the world by personal contact and all other means available.
- (2) To maintain the honor and protect the interests of the medical profession.
- (3) To study and report on the professional problems which confront the medical profession in the different countries.
- (4) To organize an exchange of information on matters of interest to the Medical profession.
- (5) To establish relations with, and to present the views of the medical profession to The World Health Organization, UNESCO and other appropriate bodies.
- (6) To assist all peoples of the world to attain the highest possible level of health.
- (7) To promote world peace.

The first meeting was devoted to matters of organization; election of officers; and outlining a specific program for the ensuing year.

The Association's unit of membership is the national medical association, which is most representative of the medical profession in the country. Each association is entitled to two delegates, two alternate delegates and as many observers as it desires. These delegates form a General Assembly which meets once a year. So far as possible, the General Assembly meets in a different country each year. The General Assembly determines all policies.

The affairs of the Association are carried on by a Council which is elected by the General Assembly. The Council consists of the President, President-Elect and Treasurer of the Association and ten members each elected for a term of three years. The Council meets twice a year.

Five General Assemblies have been held, in Paris, Geneva, London, New York and Stockholm. The mid-year meetings of the Council have been held in New York, Madrid and Copenhagen and Geneva. Its next meeting will be in Brussels. The next General Assembly will be in Athens, October 12-16, 1952.

There are now forty-three nations represented in The World Medical Association.

ACTIVITIES

The activities of the Association to date have in-

cluded the following:

1. A study of medical man power. This study shows the number of doctors in the various countries in relation to the population, and the number of general practitioners and specialists. There is a summary of the organization and functions of the national medical associations, and a discussion of the status of the medical profession. This study is constantly being revised and brought up to date.
2. A survey of medical education in some 26 countries. This compares the standards in effect in these countries. A study of this sort has never been made before. A second survey is now under way and will give the facts about individual medical schools, much along the lines of the report of the Council on Medical Education and Hospitals of the American Medical Association for schools in the United States and Canada.
3. A survey has been made of Postgraduate Medical Education in 28 countries. This includes not only specialist training but graduate training of the general practitioner.
4. There has also been a study of Cult Practice in the various countries which covers the rules and regulations governing unauthorized medical practice, the number of cultists and cultist schools.
5. A preliminary study has been made of medical advertising. This and the preceding study are being followed up to make them more complete.
6. A very full survey has been completed in Social Security as it affects Medical Practice. This study will have annual supplements, as it is a rapidly changing field.
7. There are now under way studies on the number and distribution of hospitals and the availability of certain pharmaceuticals and biologicals. These will shortly be ready for publication.
8. A quarterly Bulletin is published in three languages. This Bulletin gives the proceedings of the Association, summaries of its studies and news from all parts of the world.

We have called on all countries to protect freedom in medical research. We have condemned euthanasia.

In 1948 the Association adopted a modification of the Hippocratic Oath, known as the Declaration of Geneva. This was the result of a study of German War Crimes. As will be seen the Declaration, while simpler than the Hippocratic Oath, covers points not mentioned in the latter. The Declaration follows:

DECLARATION OF GENEVA

Adopted by the General Assembly of the World Medical Association in Geneva, September 1948

AT THE TIME of being admitted a Member of the Medical Profession

I solemnly pledge myself to consecrate my life to the service of humanity.

I will give to my teachers the respect and gratitude which is their due;

I will practice my profession with conscience and dignity;

THE health of my patient will be my first consideration;

I will respect the secrets which are confided in me;

I will maintain by all means in my power, the honor and the noble traditions of the medical profession;

MY colleagues will be my brothers;

I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient;

I will maintain the utmost respect for human life, from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity.

I make these promises solemnly, freely and upon my honor.

It is hoped that this will be required by medical schools and licensing bodies as a prerequisite to graduation or license.

A natural sequence to the Declaration was the adoption of an International Code of Medical Ethics, something which heretofore never existed. The Code is brief and is as follows:

INTERNATIONAL CODE OF MEDICAL ETHICS

Adopted by the Third General Assembly of The World Medical Association at London, England, October 1949

Duties of Doctors in General

A doctor must always maintain the highest standards of professional conduct.

A doctor must not allow himself to be influenced merely by motives of profit.

The following practices are deemed unethical:

a) Any self advertisement except such as is expressly authorized by the national code of medical ethics.

b) Taking part in any plan of medical care in which the doctor does not have professional independence.

c) To receive any money in connection with services rendered to a patient other than the acceptance of a proper professional fee, or to pay any money in the same circumstances without the knowledge of the patient.

Under no circumstances is a doctor permitted to do anything that would weaken the physical or mental resistance of a human being, except from strictly therapeutic or prophylactic indications imposed in the interest of the patient.

A doctor is advised to use great caution in publishing discoveries. The same applies to methods of treatment whose value is not recognized by the profession.

When a doctor is called upon to give evidence or a certificate he should only state that which he can verify.

Duties of Doctors to the Sick

A doctor must always bear in mind the importance of preserving human life from the time of conception until death.

A doctor owes to his patient complete loyalty and all the resources of his science. Whenever an examination or treatment is beyond his capacity he should summon another doctor who has the necessary ability.

A doctor owes to his patient absolute secrecy on all which has been confided to him or which he knows because of the confidence entrusted to him.

A doctor must give the necessary treatment in emergency, unless he is assured that it can and will be given by others.

Duties of Doctors to Each Other

A doctor ought to behave to his colleagues as he would have them behave to him.

A doctor must not entice patients from his colleagues.

A doctor must observe the principles of "The Declaration of Geneva" approved by The World Medical Association.

The Declaration is appended at the end of the Code.

UNITED STATES COMMITTEE

When The World Medical Association was first organized it was apparent that it could never be a real functioning organization without sufficient funds. Consequently, we organized a United States Committee which has been incorporated in New York as a non-profit organization. This Committee is underwriting the expenses of maintaining the Secretariat, certain expenses of the Council and the publication of the Bulletin. Membership in this Committee entitles the member to receive all the publications of the Association, including the Bulletin. Arrangements are made for members traveling in foreign countries to facilitate their visiting medical schools and hospitals. Memberships are also available for organizations as well as for individuals, and many medical organizations and organizations allied to medicine are members of the United States Committee.

WMA AND WHO

The World Medical Association has liaison with many international organizations. It has close liaison with the World Health Organization (WHO). The latter is a branch of the United Nations and it represents the governments of the world in the field of medicine. It is supported by government funds. The World Medical Association represents the doctors of the world and the medical associations. It is a non-governmental organization and its funds are received from dues and voluntary contributions.

There are many matters in which both organizations are jointly interested, such as training of medical and auxiliary personnel, an international pharma-

copoeia, international quarantine regulations, etc. In order that the viewpoint of the medical profession may be presented and upheld, the Association needs funds to do its share of the work, so that these matters will not be decided from a purely governmental standpoint.

Modern communication and transportation have made the world smaller. What happens in one area of the world may well affect another area, even though they may be separated by thousands of miles. The practicing physician, wherever he may be located, is concerned with the health of the people and the nature of the practice of medicine in other areas.

The standards of medical education and medical care in the United States are high. We can help underprivileged areas to raise their standards. These areas are calling upon us for aid, and that aid can be extended through The World Medical Association.

MEDICAL TEAMS

The Association plans, if funds become available, to send medical teams to areas lacking properly trained medical personnel, so that they may receive the benefits of modern research and practice. It also hopes to bring men from these areas to countries where they may be properly trained and then return them to their own countries where they may put to good effect the training they will have acquired. This will not only relieve local suffering, but will raise the standards of health and medical care of the world as a whole.

One of the great accomplishments of The World Medical Association has been the bringing of doctors together from all parts of the world. They have found that the language of medicine is universal. The doctors of the world think pretty much alike. Through their common bond of medical science exercised in the interest of all humanity, suspicion and distrust disappear.

It is clearly apparent that the doctors of the world must accept an international role just as they have accepted their roles as public servants to their nations and local communities. They can do this by uniting in an organization which has the strength and prestige to command respect for its opinions and recommendations.

FIRST WORLD CONFERENCE ON MEDICAL EDUCATION

Plans have been made for convoking the First World Conference on Medical Education in London, August 24-29, 1953. All concerned with medical education will be invited. The aim of the Conference will be to effect an exchange of ideas, develop possible unification of thought and to aid the underdeveloped areas of the world. The main themes to be discussed in the Conference will be:

1. Requirements for entrance to medical school, including the selection of students.
2. Social Medicine—its concepts and place in the medical curriculum.

3. The aims and content of the medical curriculum.

It is felt that the First World Conference on Medical Education will be one of the most important events in medical history. WHO is cooperating with the World Medical Association in this undertaking.

MEMBERS INVITED

All members of the Medical Society of the County of Westchester are invited to identify themselves with world health through the World Medical Association by joining its United States Committee, Inc. Membership brings with it the following:

1. *Certificate of Membership*, an introduction card to 500,000 doctors of 43 nations joined in a world-wide movement of the highest possible level of health.
2. *The World Medical Association Bulletin*, issued quarterly, and all published studies, with data nowhere else available on scientific, economic, educational, and social world trends.
3. *Letters of Introduction* to foreign medical associations and their members, facilitating professional contacts when doctors travel abroad.
4. A *share* in defending the interests of the medical profession in collaboration with other international groups, such as UNESCO and WHO.
5. *The satisfaction* of sharing the advantages of our medical progress with other lands, thus repaying a debt for the inspiration we have drawn from many countries through the generations.

Any doctor in the Medical Society of the County of Westchester may join the World Medical Association's United States Committee for \$10.00, the annual dues. The Secretariat of the Association is located in the Academy of Medicine Building, 2 East 103rd Street, New York 29, N. Y.

Help bring new hope for the health of humanity!

(Ed. Note: The invitation to join WMA extends to all members of the South Carolina Medical Association, and other recognized medical societies.)

REPORT ON BRITAIN'S EXPERIMENT

Britain's four year experiment in socialized medicine has been described in a recent issue of *The Freeman* (June 16) as a "Utopia in a Straitjacket" which has stifled medical research, degraded the doctor and virtually bankrupted the nation.

Melchior Palyi, who conducted a survey of Britain's national health program for the publication, says:

"This something-for-nothing Utopia, advertised world-wide, is now in slow retreat; the Labor government itself set a ceiling of \$1,100,000,000 on direct medical expenditures; and the conservative government is attempting to enforce it by making the patient pay roughly one-half the cost of dentures and eyeglasses, and a small fee for each prescription."

Palyi, author of "Medical Care and the Welfare State," says that in less than three years doctors wrote

609 million prescriptions, fitted 19,500,000 pairs of glasses and 130,000 hearing aids and dentists worked on seven million dentures. He added:

"The overall state of general practice is bad and still deteriorating and has reached the point where, despite the efforts of the most conscientious individual doctors, it is at best a very unsatisfactory medical service and at the worst a positive source of public danger.

"The nation's health is actually jeopardized because the exorbitant cost of over-extended curative medicine forces the shelving of urgently needed outlays to prevent the occurrence and spread of disease."

The author also asserted that under the National Health Program his on-the-spot survey showed that families are abandoning the old and the defective, who, he added, are filling the hospitals. Palyi continued:

"The public is adopting the attitude that because of the Welfare State they have no responsibilities for their aged parents."

The Freeman quoted Palyi as saying that the costs of governmentalized medicine have trebled in four years to more than 19 per cent of the national budget and added:

"Yet new hospitals are conspicuously non-existent, and the enlargement of old ones is negligible, though the lack of adequate facilities was one of the major arguments for the new scheme."

The Freeman article pointed out that under the national health plan, doctors in industrial centers are each burdened with 3,000 to 4,000 and even more registered patients.

It said that this means that a doctor has three minutes or less for a consultation with his patient during which time he should diagnose and advise, make out an ever-increasing number of prescriptions, write letters to specialists and hospitals and fill out many forms of official documents.

Palyi said that within the first three years of operation more than every second Britisher has received free dental treatment. And he warned:

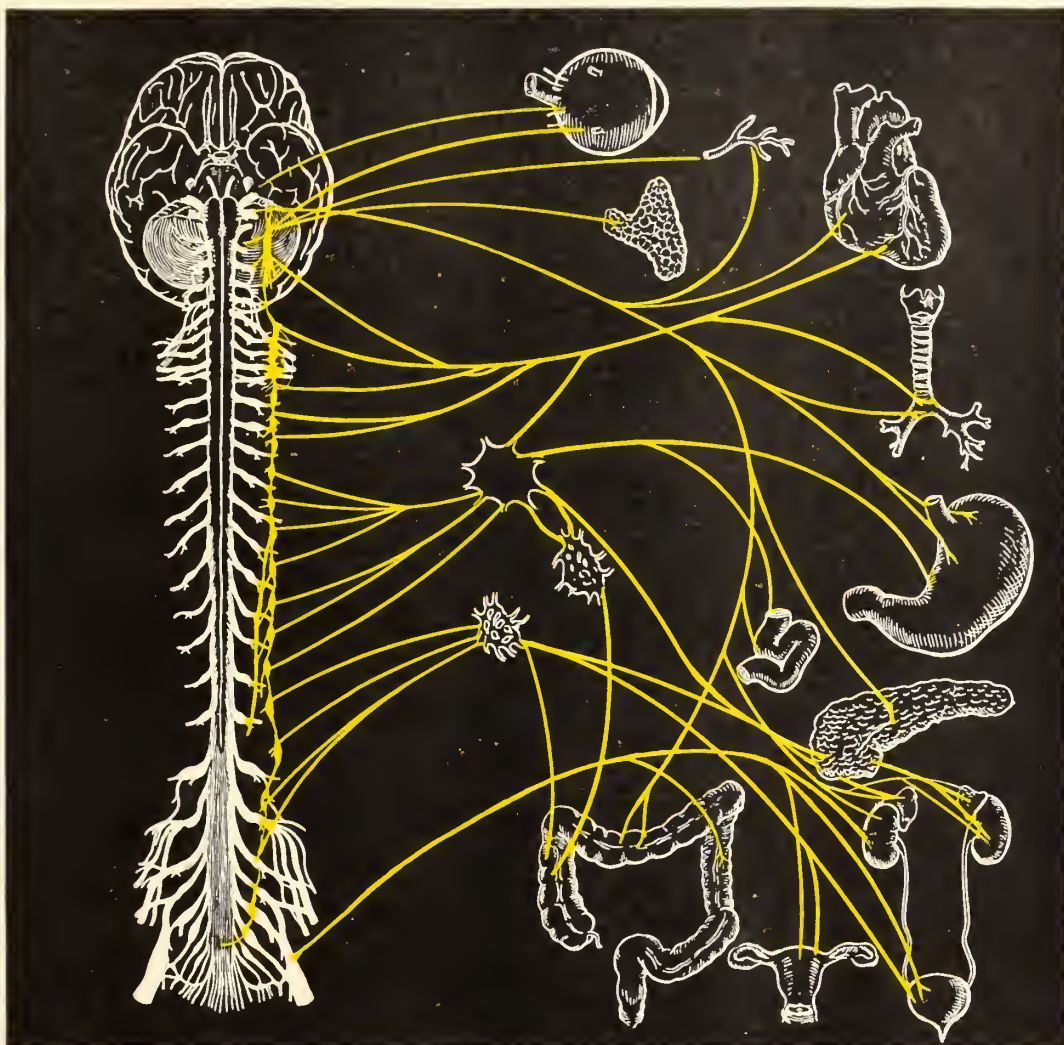
"But the dentists, rushed madly from one chair to another, are forced to sacrifice the dental care of school children whose teeth are decaying."

The Freeman stressed that under the national health program many deserving cases are obliged to wait as much as 12 months for a hospital bed because of crowded conditions and added:

"The core of the problem is the perversion of the doctor-patient relationship into a silent conspiracy to provide both partners with mutual advantages at the expense of the scheme.

"It is generally understood that deals between drug producers and panel doctors are a widespread practice."

(Reprints of the survey in booklet form are available from *The Freeman*, 240 Madison Avenue, New York 16, N. Y. at ten cents a copy).



Excess neural stimulation over the parasympathetic subdivision plays an important role in such clinical conditions as peptic ulcer, certain forms of gastritis, pylorospasm, pancreatitis, spastic colon, bladder spasm and hyperhidrosis.

Banthine[®] Bromide (brand of methantheline bromide) is a true anticholinergic which inhibits parasympathetic stimuli, acting selectively on the gastrointestinal and genitourinary systems. It exerts little or no influence on the normal cardiovascular system. Banthine is supplied in oral and parenteral dosage forms.



TEN POINT PROGRAM OF THE SOUTH CAROLINA MEDICAL ASSOCIATION

1. Cooperation

To promote closer cooperation and better understanding between all agencies, groups and individuals concerned with providing and improving medical care for the people of South Carolina.

2. Extension of Medical Care

To study constantly the need and availability of medical care in each county of the State and in the State at large.

To promote plans for providing or improving medical care where there is a need, particularly in the rural areas.

3. Pre-Paid Hospital and Medical Care

To make voluntary pre-paid hospital and sickness insurance available to all the people of the State (through Blue Cross, Blue Shield, and commercial insurance policies), and to promote the widespread purchase of such insurance.

4. Care of Indigent

To work with local county and state agencies, and with philanthropic organizations, toward securing good medical care for the indigent.

5. Public Health

To support the South Carolina State Board of Health in its broad program of preventing diseases and of safeguarding the health of our people.

6. Health Councils

To support the State Health Council in its announced program. To sponsor

the formation of a County Health Council in every county of the state, and to encourage our members to support and to work with these organizations.

7. Hospitals

To promote the expansion of present hospital facilities and the building of new hospitals—where there is a definite need.

To strive for highest standards of professional care in the hospitals in the State.

8. Medical Colleges

To support the Medical College of the State of South Carolina and to bend our efforts toward keeping its standards of education on a par with other medical colleges throughout the country.

To promote good nursing education and good nursing care throughout the State.

9. Education of the Public

To acquaint the citizens of the State with regard to the problems of medical care in existence today, to inform them as to what is being done to solve these problems, and to advise with them as to further plans for securing better health and better medical care for the people of South Carolina.

10. Political Medicine

To prevent political control or domination of medical practice or of medical education.

The Journal

of the

South Carolina Medical Association

VOLUME XLVIII

August, 1952

NUMBER 8

ONE HUNDRED AND FOURTH ANNUAL SESSION

HOUSE OF DELEGATES

SOUTH CAROLINA MEDICAL ASSOCIATION

MAY 13, 14, 15, 1952—MYRTLE BEACH, S. C.

Presiding: J. Decherd Guess, M. D., President—May 13, 1952.

THE CHAIR: The one hundred and fourth annual session of the South Carolina Medical Association House of Delegates will come to order, and I will ask for a report of the Chairman of the Committee on Credentials, Dr. John C. Sease.

DR. SEASE: We have present:

Past Presidents	7
Council	12
Delegates	31
Total	50

THE CHAIR: We have a quorum and can proceed with business.

(At this time greetings were heard from F. Earl Crawford, Secretary of the Myrtle Beach Chamber of Commerce.)

THE CHAIR: As you know, we are attempting an experiment in the conduct of the meeting of this House of Delegates this year. Whether or not this experiment will be successful will depend considerably upon you members of the House of Delegates, and perhaps even more upon the Chairmen of the Reference Committees. I hope it is going to work. I feel that if it works as it is designed to work, the conduct of the business will be handled with great dispatch and at the same time it will be conducted in a democratic manner and will serve to still the tongues of some of us who tend to complain about the way the business has been managed in the past. The personnel of the Reference Committees has been selected with much thought and great care and I want to announce those at this time.

1. **FINANCE:** The Council serves as Finance Committee and therefore matters that involve finances will be referred to the Council, as Reference Committee on Finance.

2. **Constitution and by-Laws:**

Dr. Kenneth Lynch, Chairman
Dr. Roderick MacDonald
Dr. Lesesne Smith
Dr. J. W. Chapman
Dr. Julian Price

3. **Committee on Medical Economics, Care of Indigent and Public Relations:**

Dr. V. W. Brabham, Jr., Chairman
Dr. Bob Durham
Dr. W. T. Barron
Dr. Robert Wilson, Jr.
Dr. E. B. Poole

4. **Committee on Legislation, Public Health and Public Policy:**

Dr. W. R. Wallace, Chairman
Dr. W. P. Beckman
Dr. J. L. Hughes
Dr. A. W. Browning
Dr. J. B. Floyd

5. **Credentials Committee:**

Dr. Claude Sease, Chairman
Dr. Kirby Shealy
Dr. Ned Camp

6. **Medical Association Work:**

Dr. C. N. Wyatt, Chairman
Dr. James Snyder
Dr. Clay W. Evatt
Dr. Carl A. West
Dr. Kirby Shealy

(The place of meeting of each of the committees was announced by the Chair.)

THE CHAIR: Every member of this house is not only invited but urged to appear before these committees in regard to the various matters that will be referred to them. If any members of the reference committees did not bring the mimeographed copies of reports that have been distributed through the mail, there are extra copies. Reports of officers, that were not published, may be secured from the stenographer on a loan basis. The Chairmen of the several reference committees will perhaps require stenographic service after the hearings are over, and if you wish a stenographer get in touch with Mr. Meadors.

Under this program all new business will be introduced in today's session, if physically possible. Tomorrow's meeting will have to do with consideration of Reference Committee's and will be the legislative session of the House of Delegates.

(It was announced that Dr. Tuten, immediate past president was sick and would not be able to attend, also that Dr. Olin B. Chamberlain, also a past president, was sick and would be unable to attend.)

THE CHAIR: If there is no objection I will instruct the secretary to send telegrams of regret to these two past presidents. (There was no objection and the Secretary was so instructed.)

THE CHAIR: The Report of Council, Dr. O. B. Mayer, Chairman.

REPORT OF COUNCIL

It is my pleasure again to report to you as Chairman of Council. Council's first meeting was held on May

16, 1951. At this meeting officers for the ensuing year were elected; Dr. Jeff Chapman, Vice-Chairman; Dr. Julian Price, Clerk and he was also re-elected editor of the Journal and Mr. M. L. Meadors was re-elected business manager and director of public relations. Dr. Hugh Smith tendered his resignation as delegate to the American Medical Association, which was accepted with regret. Dr. J. D. Guess was elected alternate to attend the June Meeting of the American Medical Association and Dr. William Weston, Jr., to fill the unexpired term of Dr. Hugh Smith from July 1, 1951, until the elected term of Dr. Weston, Jr., begins January 1, 1952. The treasurer was instructed, in accordance with the motion passed by the House of Delegates, to send a check for \$10,000.00 to the American Medical Association Educational Fund earmarked for the Medical College of the State of South Carolina to be used for facilities to provide for increased enrollment of the student body.

During the remainder of the year, six call meetings were held. The first one was held June 3, 1951, at which time the following budget was set up:

PRESIDENT	
No budget	
VICE-PRESIDENT	
No budget	
TREASURER	
Included with business manager	
SECRETARY	
Office help (\$1200 & \$300. office expenses (supplies, telephone & telegraph, travel)	
\$500 -----	\$ 2,000.00
EDITOR	
Salary (\$1200), office help (\$600), office expenses (\$300), plus publication of the Journal -----	2,100.00
BUSINESS MANAGER	
Salary (\$7200), office help (\$5500), travel (\$1500), rent (\$600), office supplies (\$750), tel. & tel. (\$500), heat, light, water (\$150), pub. rel. conf. (\$500), bond premium (\$155) -----	16,855.00
WOMAN'S AUXILIARY	
50c per member estimated at -----	550.00
HISTORICAL COMMISSION	
	100.00
	<hr/>
	\$21,605.00

Travel expenses of the secretary and the business manager was approved at 7c a mile and expenses for the secretary and two delegates to the American Medical Association meeting was approved as customary.

Five subsequent meetings were devoted largely to study of the problems of the State Board of Health as created by the Budget and Control Board orders. Initially, Council concerned itself with safe-guarding the interest and responsibilities of the Association and, secondly, to offer such constructive help and backing as would lead to less interference on the part of the Budget and Control Board. Fortunately for the Association, Dr. Harry Mustard was on vacation in the State at the time of these happenings, and, at Council's request, Dr. Mustard agreed to make an analysis of the situation, which he did most comprehensively and unselfishly.

With Dr. Mustard's report at hand and the Association's precedent of previously approving the report of the committee of eighteen in 1947 as regards reorganization of the State Board of Health, Council drew up proposed plans for organizational changes of the State Board of Health hoping to appeal to legislative criticisms and at the same time, further the inter-

est of the State Board of Health. The action taken on this matter by the House of Delegates at the call meeting in December, 1951, appears in the report of the secretary of the Association.

The Journal has appeared in the usual twelve issues and the general character of the publications was progressive and pleasing. Council congratulates the editor on the splendid financial showing.

A careful study of the auditor's report ending December 31, 1951, showed a total income for the year of \$62,948.25, of which approximately \$26,077.00 was collected as AMA dues, and total disbursements exclusive of the \$10,000.00 paid the American Medical Association Educational Fund, of \$57,423.43, of which approximately \$25,822.00 was paid to the AMA as dues, leaving \$21,601.43 for current expenses which gave a carry-over for the current year of \$5,524.50. Fortunately, there was a cash balance at the beginning of the year 1951 of \$14,616.34 so that after the \$10,000.00 was paid to the American Medical Association there was a total cash balance of \$10,141.16, on December 31, 1951 which is \$4,475.18 less than the balance for the year before.

A mimeographed copy of the Treasurer's report to Council is being passed to the Delegates.

The Woman's Auxiliary to the Association continues to stand by loyally and cooperates wholeheartedly in every way possible.

Council recommends that Dr. Harry Mustard be made an Honorary Member of our association. Dr. Mustard is a native South Carolinian who has distinguished himself as an authority in Public Health. He has unselfishly helped the association on many occasions by giving of his time, energy, wise counsel and expert knowledge, and this is in expression of our appreciation.

During the past year Council has not been confronted with any major problems and believes that the affairs of the association have progressed in a satisfactory manner.

The Council wishes to express appreciation to the various members of the association who have unselfishly and generously aided in carrying on the affairs of the association.

Council invites suggestions and assistance at all times so that our association may progress and carry forward in a constructive manner.

Respectfully submitted,

O. B. Mayer, M.D.,
Chairman

Thank you very much, Dr. Mayer, Council has had a busy year and accomplished a great deal for the Association and for the doctors of the state.

We will deviate from the usual order of business to act on recommendation of Council, with regard to honorary membership for Dr. Harry Mustard.

(Dr. Charles N. Wyatt, of Greenville, S. C., moved that Dr. Harry Mustard be so honored by the association. This was seconded by Clay W. Evatt, M. D., Charleston, S. C. There was no discussion and the motion was unanimously carried.)

THE CHAIR: The secretary is to write Dr. Mustard and tell him he has been so honored.

The report of Council will be referred to the Reference Committee on Medical Association Work.

The President's Report has been printed and distributed to you, and as there are no supplemental remarks his report is referred to the reference committee on Medical Association Work.

REPORT of business manager and Director of Public Relations, Mr. M. L. Meadors.

From the standpoint of its business administration, collection of dues and other income, growth and acquisition of members the South Carolina Medical

Association has had a very successful year. As appears from the report of the annual audit which is available to Council, dues were collected during 1951 from members of the State Association in the amount of \$17,682.00. Journal subscriptions, which are \$3.00 of the \$20.00 annual payment by each member, amounted to \$3,103.25. Advertising in the Journal produced \$12,936.91, and there was credited to the general fund, after payment of certain expenses in connection with the 1951 meeting, a balance of \$2,317.58 from the exhibits last year. These items made up the bulk of the Association's income of \$36,870.53.

In addition to these amounts, we collected, as agent for the A. M. A., \$26,077.72 in dues to that organization, and in turn remitted to the A. M. A. during the year a total of \$25,822.50. There was a balance of cash on hand and in the bank at the beginning of 1951, exclusive of the reserve fund, of \$14,816.34. Adding to this figure, all of the collections referred to above and amounting to \$62,948.25, there was a total of \$77,564.59 handled by the business office during 1951. The principal items of expense were for print of the Journal, \$7,386.38, and salaries.

The donation of \$10,000.00 to the National Education Foundation, authorized by the House of Delegates last year, and earmarked for the Medical College of South Carolina, was paid from the general fund, and the Association's reserves were not disturbed. The latter, amounting to a total of \$25,000.00, represented by Government Bonds of \$10,000.00, Deposit in Savings and Loan Association, \$5,000.00, and note of the South Carolina Medical Care Plan in the amount of \$10,000.00.

The total membership of the Association as of December 31, 1951, was 1,204. Of this number, according to the official records of the A. M. A. on December 1, 1951, 1,081 were also members of that organization (12/1/51). While we do not have definite information, we believe that, percentage-wise, this compares favorably with the record of any state for membership in the AMA.

For 1952 the collections already thus far have been almost as good. As of May 1 of this year the office had received state dues from 742 (1950-1951—23) and those from the AMA from 708 (1950-1951)—40) members.

One feature of the membership in the past year which is worthy of note, is the number of new members. During 1951 we added to the rolls a total of 102 members and so far this year there has been an addition of 36 members. During the same length of time, we have lost, by death and otherwise, a total of 109 leaving a net gain of 29 members.

All of the records pertaining to the business administration are kept in our office, through which funds and collections from all sources are channeled.

A complete new set of books and system of records have been set up within the past year. This was almost necessitated by the increase in the amount of record work entailed in the collection of dues to the AMA. The ledger sheets now show, in parallel columns, the record of payment of dues of each physician to the state and the AMA for a period of six years. The record indicates in each instance the date and source of payment, and in the case of AMA dues, the date of their remittance to Chicago. All dues are acknowledged immediately upon receipt and membership cards are mailed to the paying members as soon thereafter as the time required for processing and entry of the necessary records will permit. Dues are remitted to AMA once a month, usually by the tenth, and a copy of the members paying dues to the S. C. and AMA is transmitted at the same time to the office of the Secretary, Dr. Heyward.

Complying with a recommendation of the Committee on Public Relations, Dr. William Weston, Jr., at the last annual meeting, the membership cards for 1952 carry on the back The Ten Point Program in abbreviated form.

Last fall we worked with Council in connection with the study of the State Board of Health. Subsequently, copies of the resolution adopted by Council were mimeographed for the House of Delegates prior to the called meeting of that body in December. Thereafter and acting under the direct instructions of the Chairman of the committee designated by the House of Delegates to originate and steer through the General Assembly the Bill for reorganization of the Board of Health, we prepared the Bill, following strictly the substitute resolution which was adopted by the House of Delegates in December. In February, we appeared with Dr. Mayer, Dr. Heyward and Dr. Pressly before the Committee on Military, Public and Municipal Affairs, which adopted and introduced the measure as a committee bill.

Later, we appeared also with Dr. Guess and Dr. Cantey before the Senate Committee on Medical Affairs when a public hearing was held on the Bill. The Committee decided to continue the Bill, which, therefore did not reach the Senate floor for debate.

At the beginning of the year, we were appointed by the President, *ex officio* or as Counsel to six of the standing committees, and have undertaken to assist when called upon, or whenever the opportunity arose to do so.

In June of last year we attended the meeting of AMA in Atlantic City and in December the interim session of the House of Delegates and the Conference on Public Relations, in connection therewith, in Los Angeles. Both of these meetings served the useful purpose, as always, of enabling us to keep directly in touch with the administrative personnel and Legislative policy of the American Medical Association and the various State organizations.

In December and the first few months of this year we handled in South Carolina, the essay contest of the Association of American Physicians and Surgeons. This contest, on the subject "Why the Private Practice of Medicine Furnishes This Country With The Finest Medical Care," was participated in by students of the High Schools and Junior High Schools throughout the country.

Each county Medical Society was requested by letters to the secretaries, to participate likewise by offering separate local prizes for the best essays written by students within their respective counties. Because a number of the county organizations complied with this suggestion, judged their own essays and sent in to us only the winners, we are not in position to make a definite report as to the total number of students who submitted essays. Most of the Counties received these direct. We received in the state office approximately 55 essays, and from these the judges selected the three considered best, which, in turn were sent to Chicago for judging in the National Contest. The writer of the winning essay, in the State Contest, Mr. W. Byrd Lewis, of Pickens, has been invited to this meeting as a guest of the Association and will be presented first prize on Thursday afternoon.

A total of 38 commercial exhibitors have bought spaces for their displays at the meeting this year for a total of \$3,200.00. This amount again is more than sufficient to bear the cost of the annual meeting, and in turn the exhibitors are entitled to the consideration of the members of the Association, all of whom are urged to visit as many of the exhibits as possible.

Cooperating in an innovation this year, designed to expedite the work of the House of Delegates and in

line with the new schedule of the business sessions, we mailed to each member of the House and each alternate, prior to the meeting, copies of the various committee reports. These reports were sent in to the Secretary in April and forwarded by him to our office, where they were mimeographed and on May 1, copies of 15 such reports, together with the President's letter of transmittal a total of 40 pages, were mailed to each member and alternate, some 8,000 mimeographed sheets being involved in this operation alone.

We have tried to keep in touch with legislative activities on the national level and likewise within the State. With the exception of the proposed bill concerning the State Board of Health, nothing of particular interest developed in the General Assembly this year.

Following the usual custom we have undertaken to keep the members informed through the Ten Point Program Department of the Association Journal on matters of interest to them, connected with medical economics, legislation and public policy. A number of talks have been made before service clubs and civic organizations, medical societies and auxiliaries, throughout the State, and no opportunity to represent the interests of medical profession in this capacity has been neglected.

We handled with the Ocean Forest Hotel all of the arrangements for the present meeting, supervised the arrangement and printing of the programs, and in general have undertaken to care for all the administrative work properly within the scope of our office.

Generally speaking, the business affairs and, we believe, the Public Relations of the Association are in excellent condition. Judging from the response of the members and their early payment of dues it would appear that this general sentiment as to the success of the Association's operations is shared generally by the members of the organization.

Respectfully submitted,
M. L. Meadors

REPORT—The Secretary, Dr. N. B. Heyward, Columbia, S. C.

Mr. President, and Members of the House of Delegates:

First, I would like to take this occasion to thank the Secretaries of the component societies, and the Chairmen of the various committees, for responding to requests for a list of their officers and delegates, on the one hand, and for the reports of committee activities, on the other hand. The delegates have, as a result, received information on the principal matters to be presented to them for consideration, and are enabled to come to the meeting with first hand information on matters to be considered, and to vote their convictions on each one. In my visits over the State, I have been stressing the importance of each member receiving this information; as has our President, Dr. Guess. The members of the component societies seemed interested in the state-wide matters brought to their attention, and asked many questions regarding them. It made one feel that the effort was worthwhile.

The time of your Secretary was taken up largely, during the first half of the year, by the meetings of Council regarding the activities related to the abortive effort to give the State Board of Health back to the State of South Carolina, since, apparently, there was dissatisfaction with the manner with which we were conducting it. As you remember, there was a Called Meeting of the House of Delegates on December the 9th of 1951 to adopt resolutions surrendering the control of the State Board of Health to the Governor. In

the February, 1952 issue of the *State Journal*, Dr. Guess gave a resumé of the meeting and the full minutes of that meeting will appear in an early issue of the *Journal*. At least we can be credited with making a sincere effort to give the Governor complete control of the situation. The House of Representatives gave our bill a respectful hearing and then passed it. The Senate was not so considerate. Two surprises, incidentally, were uncovered in the effort to get the bill through the Senate: the first being the rumor that the South Carolina Medical Association was making this effort in order to get rid of Dr. Ben Wynman, and the second, the rumor that a prominent member of the South Carolina Medical Association was very much interested in getting Dr. Wynman's position, when and if the bill was passed and the reorganization of the State Board of Health was accomplished. I was very much surprised at both rumors, one of which, I am sure, was not true. Our bill was never referred out of the Medical Affairs Committee of the Senate, and so is now dead.

The Committees appointed by our President seemed to have an added interest in their assignments and turned in reports indicating considerable activity in their respective fields. I feel sure that this added interest was stimulated by the interest and activity, in the affairs of the Association, taken by our President, Dr. Guess.

Changes have been made, and more are planned, in the order of business of the Association, and in the responsibility and activity of the officers of your Association, demoting your three highest officers to so called honorary positions, and taking away most of their activities. These changes can be carried too far in an Association as small as ours, and I urge your careful consideration of the changes planned.

Your Secretary took the lead in the fight against changing the method of issuing licenses by the various examining boards in the State and, along with the secretaries of other boards, was able to persuade the House of Representatives to vote down Reorganization Plan No. 9, thus leaving the boards to function as usual. Reorganization Plan No. 9 would have made the boards less efficient, less economical, and of less service to the public. I am convinced that the change would have been a backward step.

In closing, I would like to call to your attention that some of our members are indifferent in sending in their dues for the American Medical Association. As of December 1st of 1950, the membership of our Association in the American Medical Association numbered 1181; as of December 1st of 1951, the membership was 1081. As you probably know, we are entitled to one delegate to the American Medical Association for every 1000, or fraction thereof, paid-up memberships in the National Association.

Respectfully submitted,
N. B. Heyward, M. D.
Secretary

THE CHAIR: There is one important matter I overlooked—the minutes of the last regular meeting were published in the August Issue of the *Journal*,—would the House care to have those minutes read or will they accept them as published? What is your pleasure?

(R. W. Hancel, Charleston, moved they be accepted as published; this was seconded by Dr. Weston; there was no discussion, and the motion was unanimously carried.)

THE CHAIR: There was a call meeting of the House on December 8, 1951.—the minutes of that meeting have never been published. Would you have the minutes of that meeting read or are you familiar

enough with the business that was transacted (that was the business regarding the State Board of Health, and authorizing the change of the program in this meeting) to approve them without being read?

(Dr. Cain moved that the reading of the minutes of the meeting of December 8, 1951 be dispensed with; this motion was seconded and unanimously passed.)

THE CHAIR: Those minutes will be published, they have been furnished to the Editor but got in too late for publication.

The Report of the Secretary will be referred to the Reference Committee on Medical Association Work.

In case of the reports that have been printed and published, the Chairmen of those various committees will be given an opportunity to make a supplementary report, reporting on matters that may have occurred since their reports were made.

REPORT—The next report I will call for will be the supplementary report of the Executive Committee of the State Board of Health, have you any supplementary remarks you wish to make, Dr. Wallace?

DR. WM. R. WALLACE: I have no supplementary report to make, the report has been published and is in your hands. I would like to say, however, that we feel the affairs of the Board of Health have made considerable improvement and I feel that the Control Board is gradually lessening its grip on the Executive Committee, and a great many difficulties in the expenditure of funds have been removed. The Legislature seems to be more sympathetic with the State Board of Health, regardless of the things that have gone on, and this year has increased the appropriation by about one-half million dollars. Last year we had an apparent increase but also had an increase of 100% in salaries, which was therefore a considerable decrease. I am sorry to say the Federal Government has decreased their appropriation about Fifty Thousand (\$50,000) Dollars this year. All in all we think, of course the legislature has adjourned since my report was written, that everything looks more encouraging for the affairs of the State Board of Health. Thank you, sir.

THE CHAIR: Dr. Wallace's report will be referred to the committee on Legislation, Public Health and Public Policy.

THE CHAIR: The Chair takes pleasure in presenting the President-Elect, Dr. Lawrence P. Thackston, who will address the House at this time?

DR. LAWRENCE P. THACKSTON: Mr. President, ladies and gentlemen, I am filled with a great deal of dread, to be perfectly honest, in anticipation of the many problems we are faced with. I feel that we are going to be extremely aggressive and that each of us is going to have to take upon himself a feeling of personal responsibility if we are to continue medicine as we like to have it. I am certain that we are faced with brilliant and unscrupulous enemies who would like to see our profession subject to authority completely on a National level. As President-Elect, and I hope as President, Thursday, I want to ask you individually to pledge yourself to exert your utmost ability and effort to fight these forces. Thank you.

THE CHAIR: Thank you for the thoughtful remarks, we wish to take them to heart.

REPORT: Delegate to A. M. A., Dr. William Weston, Jr.

I met with the delegates of the American Medical Association, in Los Angeles, December, 1951, concluding it was best for me to observe the sign which one sees when he is approaching a railroad crossing, "Stop, Look, and Listen." Consequently, I picked up

valuable experience and met many of the leaders in our profession.

I was impressed by the seriousness and the amount of information that a great number of this body seemed to have in store. Numerous resolutions were presented and referred to their appropriate reference committees, which number fourteen. Each resolution is discussed freely in committee meetings and any member of the American Medical Association is permitted to attend, if one so desires, besides any member of the House of Delegates. The findings of the committee are brought back to the House of Delegates with their recommendations and passed or rejected by this body. The Officers and the Board of Trustees of the American Medical Association are men of ability. Most of them have given unstintingly of their time. They are polite and courteous in answering your questions. They are a group of men upon whom we can rely and they certainly deserve cooperation, with which this group, the South Carolina Medical Association is fully in accord. There is not much time for relaxation during the sessions but there is usually a cocktail hour following the afternoon session before dinner. Here one may meet other delegates and express his views a little more freely.

The sessions are not continuous as it is expected that the delegates attend the scientific meetings, also the commercial and scientific exhibits which both play an important part in the successful outcome of a convention, particularly medical. There were two paramount subjects with which the American Medical Association was most definitely concerned; first, the prevention of the socialization of the medical profession and the preservation of its independence from political influences. All of you are familiar with the fight that has had to be carried on as this is the chief item responsible for the raising of our medical dues in the past three years. The firm of Whitaker and Baxter have done a splendid job. A number of allied professions and various organizations have realized the fight that we are successfully carrying on. They have joined us financially, politically, economically, morally, and spiritually in helping us carry out our "unalienable rights and the pursuit of happiness," which one will not find in the slave labor of socialized medicine. We trust that Ewingism and Socialism are on the way out.

The second matter most emphasized was the Education program. All seem to feel that this movement successfully correlates with the first mentioned. The American Medical Association and individual physicians have given more than 2½ million dollars toward promoting medical education. This sum has been substantially augmented by considerable sums of money from other sources. The help to medical colleges has been most important and its psychological effect has been spectacular. It has given the lie to Ewing in his assertion that doctors do not wish expansion of admissions to the medical colleges when the facts are indisputable that the doctors are working and giving generously of their means to provide facilities for increasing admission to medical students without lowering the high standards that they (the doctors) have set to make more and better doctors.

Among the outstanding features of the Los Angeles meeting were the addresses of the President of the American Legion, Mr. Donald Wilson, Commentator of the American Legion and Senators Taft and Byrd. The President of the American Medical Association, Dr. John Cline, made a forceful and highly intelligent dissertation. Mr. Wilson's address was forceful and highly complimentary of the great fight that has been and is being made by the American Medical Association.

tion against socialism and all its widespread iniquities. He promised full and hearty support by the American Legion.

The addresses of Senators Taft and Byrd were masterpieces of fine analytical logic. Both speakers praised the American Medical Association for their splendid contribution against socialism. Both brought out quite clearly that the "New Fair Deal" program was inevitably leading to tyranny, dictatorship, loss of personal freedom and hopeless bankruptcy.

These splendid addresses are printed in full in the December 22nd, 1951, issue of the Journal of the American Medical Association. I hope each member of the South Carolina Medical Association, if he has not already read them, will do so.

It was voted to continue the interim sessions of the American Medical Association. The purpose of these sessions was mainly for the business to be transacted and for the benefit of the general practitioners.

The theme of the meeting was, "A Thin Beltline Means a Long Life Line."

Respectfully submitted,
William Weston, Jr., M. D.
Delegate from South Carolina
to the American Medical Association

THE CHAIR: Dr. Julian Price, the other delegate to A. M. A., published his report as a travelogue, and he states that is sufficient.

Dr. Weston's report will be received simply as information.

REPORT—State Board of Medical Examiners, Dr. N. B. Heyward, Secretary.

Licensed by examination	63
Licensed by reciprocity	56
Total licensed	119
Duplicate licenses	5
Licenses certified	41
Expenses of Board for 1951	\$3,004.63
Receipts of Board for 1951	\$4,810.00

The effort of the Governor to change the system of issuing licenses was defeated in the Legislature by the leadership and forethought of the Board of Medical Examiners.

Respectfully submitted,
N. B. Heyward, M. D.
Secretary

REPORT—of the Committee on Cancer Control, Dr. J. R. Young, Chairman.

THE CHAIR: This report has been published and distributed to you by mail. Is there a supplemental report the committee would like to make at this time? There being none the report will be referred to the Committee on Legislation, Public Health and Public Policy.

REPORT—The report of the Committee to consider Petition of Negro Physicians in the State Association has also been published.

THE CHAIR: I will ask Dr. Price, a member of the committee, if he has any supplemental report to make. Since he has none, that report will be referred to the Committee on Constitution and By-Laws.

REPORT—The report of the S. C. Advisory Committee to Selective Service, Dr. Owens, has been published and has been sent out to members of the House. The distribution was made rather late, is there any member of the House who did not get a copy of Dr. Owens report.

(Dr. Owens was asked for a report and he gave a brief resumé of his report)

THE CHAIR: We owe the committee a deep debt of gratitude for their work and the kindness and fairness with which they are doing it. This report will be referred to the Reference Committee on Medical Economics, Care of the Indigent, and Public Relations.

REPORT—Report of the Committee on Revision of the Constitution and By-Laws, Dr. Julian Price.

DR. JULIAN PRICE: It was the problem of this committee to bring the Constitution and By-Laws up to date, making minor changes in the wording and making certain definite changes in the content. We have tried to make this as simple and easy to understand as possible, because there is a possibility of becoming confused. (Mimeographed copies of the Constitution and By-Laws, setting forth the proposed changes are handed to each member.) What you have before you is a complete mimeographed copy of the Constitution and By-Laws, as they now exist. All of that is in the mimeographed material which is not underlined. All of that which is underlined consists of the changes which the Committee recommends. As you look through it, therefore, you will notice that we are going to skip those parts which are not underlined, and only consider those which are underlined. Wherever you find a section or a paragraph underlined, it takes the place of the preceding section.

The proposed changes in the Constitution must of necessity lie on the table for one year.

The amendments to the By-Laws can be changed at this session by a vote tomorrow morning.

(Each change is taken up in detail and read and explained, at the close of the explanation Dr. Price said:

That is our report. I want to thank the members of the committee who have really worked on this assignment: Dr. J. D. Guess, Dr. N. B. Heyward and Dr. O. B. Mayer.

Let me reiterate what I have said before, the proposed changes in the Constitution are put on the table so that we will have an opportunity to discuss them during the next year, with the simple exception of the question of whether we want to have a Speaker of the House of Delegates.

THE CHAIR: Thank you, Dr. Price. I am sure you realize, gentlemen, this committee has worked very hard on this matter and you realize it has been presented in excellent fashion. I hope during the luncheon recess you will read the copy of proposed changes and make some marginal notes and in case you have an opinion be prepared to present that opinion to the Reference Committee this afternoon. This is referred to the Reference Committee on Constitution and By-Laws and I will ask that committee in their consideration to take into consideration the Action of the House with regard to whether or not we do have a speaker, and also the recommendations of the Committee with regard to the changes in the Constitution, which we can not act on this time, but which do influence in certain particulars the proposed changes of the By-Laws. Dr. Lynch is chairman of that Reference Committee.

DR. KENNETH LYNCH: If it is appropriate to make certain clarifications here, in preparation for the work this afternoon, I would like to be heard.

THE CHAIR: Yes, if you wish.

DR. LYNCH: This is perhaps in the nature of a request for rulings. In the first place, the most of these proposed amendments to the Constitution are not to be considered until next year,—it appeared to me to be out of the province of the Reference Committee this year,—that will become the business of the Reference Committee next year. Is that correct?

THE CHAIR: That is correct, sir. I do hope you will take into consideration these proposed changes in the constitution as they may have a bearing on the changes of the By-Laws.

DR. LYNCH: That brings me to my next question, a good many of the proposed changes in the By-Laws are contingent upon proposed changes in the Constitution, which can not be even reported upon until next year. Therefore, it would appear to me that the Reference Committee of this year must confine itself to amendments to the By-Laws as they relate to the Constitution, now in force, and not a proposed change in the Constitution next year. That would be my attitude about that.

Now, there are a good many proposed changes in the By-Laws, here, which could be acted upon this year except for the fact that in effect they change the Constitution, even though the Constitution can't be changed until next year. It strikes me that is apt to be something of a conflict.

DR. JULIAN PRICE: The changes that are proposed in the amendments to the By-Laws will apply to one change in the Constitution, only, and that is the Election of a Speaker of the House. That was laid on the table last year and it can be voted on this year. If that is acted on, I think most of the changes in the By-laws can go into effect.

DR. LYNCH: If it is not acted on, then they will be all thrown out?

DR. JULIAN PRICE: Yes.

DR. LYNCH: The third question,—we have here a proposed change of the Constitution, relating to a Speaker of the House of Delegates, by a special committee reporting today. Now, was there or was there not a proposed change to the Constitution offered last year and if so what is that, is it the same as this? I would like to see the original wording of that as proposed last year.

THE CHAIR: The change you are referring to has to do with the matter of whether we would have a speaker of the house. That has been laid on the table one year and that can be voted upon.

DR. JOE CAIN: I want to ask a question. Are the proposals that have been made by Dr. Price, have they been presented to this assembly already or will those proposals be presented through the Committee after they have met?

THE CHAIR: They will be presented to the House through the Reference Committee. The Constitutional Amendments will lie on the table a year.

DR. JOE CAIN: Have the proposals already been made by Dr. Price or do the proposals have to come out from the Committee?

THE CHAIR: The proposals about the change in the Constitution have now been proposed by Dr. Price.

DR. JOE CAIN: In other words, they will now lie on the table?

THE CHAIR: Yes, sir.

DR. LYNCH: I have the wording now of the proposal made last year and I think that clears the deck for action this afternoon.

THE CHAIR: You will have lots to talk about during luncheon recess in connection with these proposals.

REPORT—Committee on Legislation, Public Health and Public Policy.

THE CHAIR: Has that committee a supplemental report to make, Dr. Cantey? (Dr. Cantey replied in the negative) Then that report will be referred to the Reference Committee on Legislation, Public Health and Public Policy.

THE CHAIR: Is there a supplemental report of the Committee on Public Health and Instruction, Dr. J. P. Harrison? (There was none) There being no supplemental report, that report is referred to the Reference Committee on Legislation, Public Health and Public Policy.

Is there a supplementary report of the Committee on Medical Education, Dr. Coldsmith? (Dr. Goldsmith stated there was no further report) If there is none that report is referred to the Reference Committee on Medical Association Work.

REPORT—Advisory Council to Medical Auxiliary (No Report)

THE CHAIR: Is there a supplemental report of the Committee on Historical Medicine? (Dr. Waring stated there was no supplemental report)

THE CHAIR: That report on Historical Medicine has been distributed and it requests an appropriation of funds and it is referred to the Finance Committee, or to the Council as Committee on Finances.

Is there a supplemental report on Infant Mortality? (There was none) That report requests an appropriation and it is referred to Council, as the Finance Committee.

Is there a supplemental report of the Committee on Maternal Welfare. That report is referred to the Reference Committee on Legislation, Public Health and Public Policy.

Is there a report of the Committee on Public Relations, Dr. Boggs? (There was no report)

Is there a supplementary report of the Committee on Industrial Health (There was none) That report has been distributed to us, and is referred to the Reference Committee on Constitution and By-Laws.

Is there a supplementary report of the Committee on Rural Health, Dr. Kitchens? (Dr. Kitchens not present) That report is referred to the Reference Committee on Medical Economics, Care of Indigent and Public Relations.

Is there a report of the Committee on Liaison with South Carolina Nurses Association, Dr. J. D. Parker? (No report)

Is there a report of the Committee on Medical Care of Veterans, Dr. Izard Josey? (No report)

THE CHAIR: This shows you what an innumerable number of committees we have and how little work they find to do.

Is there a report of the Committee on Hospital Service, Dr. Furman Wallace? (No report)

Is there a report of the Committee on Membership, Dr. Nesbitt? (No report)

Is there a supplementary report of the Committee on Industrial Fee Schedule, Dr. Frank Owens? That report has been distributed by Dr. Frank Owens, we will ask him to make a supplemental report and bring us up to date.

DR. FRANK OWENS: I have no supplemental report.

THE CHAIR: This report of this committee is referred to the Reference Committee on Medical Economics, Care of Indigent and Public Relations.

Is there a supplementary report of the Committee on Medical Care of the Indigent, Dr. Webb? If not that report is referred to the Reference Committee on Medical Economics, Care of the Indigent and Public Relations.

Is there a supplemental report of the Special committee on Ways and Means of Establishing a State Hospital for Chronic Alcoholics, Dr. Alford? (Dr. Alford stated there was no supplemental report)

THE CHAIR: You wrote a fine report. Dr. Alford's Committee has done a lot of study on that problem. His report will be referred to the reference Committee on Legislation, Public Health and Public Policy. I hope Dr. Alford will appear before that Committee and discuss that report with them, it contains some very definite recommendations.

Is there a report of the Special Committee to Investigate Feasibility of Establishing a Medical Examiners System, Dr. Strother Pope? (No report)

THE CHAIR: That is rather disappointing. Dr. Pope had a fine report and was made Chairman of this Special Committee which he asked to be set-up,—also this committee worked with a similar committee that was formed by the State Bar Association.

Is there a supplementary report of Association's Representative at Meeting of American Medical Education Foundation, Dr. John T. Cuttino? (There was no supplemental report)

THE CHAIR: He is not here because of weather conditions, his plane was grounded, but he has written a summary of the action and that has been published in his report. It will be referred to the Finance Committee, Council, as a reference Committee.

Is there a report of the Special Committee to Investigate Feasibility of Establishing a School of Dentistry at the Medical College, Dr. Martin? If he is not present is any member of his committee present? (No Report)

Next, is a report of the Special Committee to Seek Legislative Action Implementing our Recommendations Changing the Set-up of State Board of Health? I was made Chairman by action of the House at the special meeting on December 8th and the report of that Committee was really incorporated in the report of Committee on Legislation and Public Policy and, in addition to that, a report was published on the President's page of the Journal. Those reports are referred to the Reference Committee on Legislation, Public Health and Public Policy.

DR. N. B. HEYWARD (The Secretary) There is a proposed amendment to the Constitution, Article V, Section (2) (reading) "The House of Delegates shall elect annually a Speaker of the House who shall verse himself in Parliamentary Law." This has lain on the table for one year.

THE CHAIR: What will you do with this matter, what is your pleasure with respect to the proposal to elect each year a Speaker of the House?

Dr. Chas. N. Wyatt moved the adoption of the amendment. This was seconded by Dr. Goldsmith. The Chair called for a discussion.

DR. ROBERT WILSON: I don't think it is altogether clear as the amendment is written,—and a lot of things come to mind. First of all it should be understood when the Speaker should be elected, and at what meeting he should preside. Second, it doesn't state whether the Speaker of the House shall be a member of the House, it is conceivable he might be elected as Speaker of the House and his county society not return him as an official delegate, what would be his status? Those things should be considered and clarified. I am in favor of adopting the amendment, but these matters should be considered regarding the implementation of the idea.

THE CHAIR: Do you have ideas you could state in the form of a motion?

DR. ROBERT WILSON: I would suggest that the Speaker of the House not necessarily be an elected delegate or member of the House, but that he be a delegate at large, perhaps elected by the House and automatically become a member of the house, as Speaker.

THE CHAIR: You offer that as an amendment to the amendment?

DR. ROBERT WILSON: Yes, that he need not necessarily be a member of the House, an authorized delegate, but naturally a member of the Association, and that he be elected at the meeting of the House of Delegates to preside at the proceedings of the House of Delegates the following year.

THE CHAIR: You offer that as an amendment to the amendment?

DR. WILSON: Yes.

THE CHAIR: Is there a second to Dr. Wilson's proposed amendment to the amendment under consideration? (The motion was seconded.)

Is there any discussion?

DR. JULIAN PRICE: We do not have this change in writing. One of the greatest difficulties has been getting the exact wording of the Constitution and By-Laws. It is one thing for a person to stand up and talk and another thing to put it in actual words. I move, as a substitute motion, that this matter be referred to the Committee on Constitution and By-Laws to be brought in with their report tomorrow morning.

THE CHAIR: It has been moved that the motion of Dr. Wilson be referred to the Committee on Constitution and By-Laws to report back to the house, is there a second to Dr. Price's motion?

(Dr. Evatt seconded Dr. Price's motion)

DR. WESTON, SR.—Is it not true, should this amendment be passed or approved, that it would postpone any change in the Constitution for another year?

THE CHAIR: I think not. It is within the limits of Parliamentary Law to amend and act on the amendment at this meeting of a proposed amendment to the Constitution that has lain on the table for a year. In other words, the main question, is whether or not we shall have a Speaker of the House.

MEMBER: My personal feeling is if Dr. Price's motion prevails it will put the Reference Committee on Constitution and By-Laws somewhat on the spot and will have negated an answer to Dr. Lynch's question a little while ago. I suggest that we adopt or reject, at your will, the matter of whether or not we shall have a Speaker of the House and then refer the regulations, the limiting regulations, the provision that Dr. Wilson has proposed, to the Committee on Constitution and By-Laws. I think that a preferable way to handle it and will put the reference committee in a position where they can go ahead.

DR. JULIAN PRICE: I will withdraw my motion, provided Dr. Wilson puts that amendment of his in writing.

THE CHAIR: Dr. Wilson, will you put that in writing so that it will be in condition to refer to the reference committee.

DR. VANCE W. BRABHAM: I would ask for somebody who knows the advantages of a Speaker to tell this gathering what the advantages are, what we will gain by a Speaker, and if anybody knows—what we will lose by having a Speaker of the House?

THE CHAIR: Let's discuss the motion before the House, and the motion is that we amend the Constitution providing for a speaker who shall be well versed in Parliamentary law. Dr. Brabham wants to know why we need a speaker. This proposal was advocated by a member of this House, perhaps he would like to discuss it.

DR. CHAS. N. WYATT: Members of the House of Delegates, I proposed that amendment last year and the main reason for my proposal was the fact that the

business of the House of Delegates was getting so large and involved and taking so much time that it would give the President of the Association a little more time to get out and enjoy mingling with the members of the Association and give him a little more freedom in the session that we have annually.

Another thing, if you have a Speaker of the House who has had time or has had experience, or can learn and most of them can, parliamentary law, that with the institution of this new program we are trying this year the business of the House of Delegates can be expedited and we can get on with the scientific program of the Association. This thing is not new, it wasn't original with me, but I have been to meetings where such a program prevailed and it certainly was a big help and it certainly took a big load off the presiding officer of the Association, that is, the President. It doesn't necessarily add any more on us, it will be a job, as you can well see and have seen over a period of years in this House of Delegates, it is a means or rather a proposed method of getting the thing in order and expediting the business of the House of Delegates so that the thing doesn't drag on infinitum, as it has in years gone by.

In the third place it will tend to create less confusion in the presentation of the proposals and resolutions before this House of Delegates and can be held down and can be controlled by one presiding who knows parliamentary law, as we have encountered year after year. Proposals have been made, counter proposals have been made and the whole thing blocked out and nobody knew where we stood. As you remember, the officers of this association were elected two or three years ago and then the duties of them were taken away. It is a way in a more proper and businesslike way to a proceeding of the House of Delegates.

It was not my purpose to create any office or any honor, it will be work on the part of the individual so elected. I don't think he necessarily has to be a member of the House of Delegates and he should be elected annually and if he is elected one year and he proves out all right he can be re-elected. It is something to bring our Association a little more up-to-date than we have been heretofore.

DR. BROWNING: That would be a salaried position?

DR. WYATT: No, he might wish it was, but no.

THE CHAIR: We are handling this a little irregularly. Dr. Wilson's amendment is now in writing, let him read that to you, and then the proposal to create the Speaker of the House, the main question with the amendment as proposed by Dr. Wilson will be open for discussion.

DR. WILSON: "The speaker shall be elected, at the annual election of officers, at each annual meeting and shall preside over all sessions of the House of Delegates until his successor is chosen. He shall not necessarily be a delegate from any component county society but may be any member of the Association at large."

THE CHAIR: That means, in addition to the stated amendment, that the House shall have a Speaker, the Speaker shall be elected at the annual election of officers, at each annual meeting and shall preside over all meetings of the House of Delegates until his successor is chosen, he need not be a member of the House of Delegates but may be any member of the Association at large. The question before the house is shall we amend the Constitution to provide for a Speaker of the House and shall that proposal, as amended by Dr. Wilson obtain? It is open for general discussion.

DR. WM. WESTON, SR.: In view of the fact we

are operating under the Constitution as it now stands, and that this clarifies an amendment which is of great importance, I think it so changes that amendment that it seems to me that would have to lie over to another year.

THE CHAIR: Dr. Weston, the Chair is going to rule otherwise. The law, parliamentary law, is that a proposed amendment to the Constitution must lie on the table for one year, but a proposed amendment to that amendment does not. It can be considered at the time that the proposed amendment is submitted.

DR. WM. WESTON, SR.: I submit that isn't the case. This is a new amendment, making, of course, a provision for a Speaker of the House.

THE CHAIR: The proposed amendment to the Constitution provides for the Speaker of the House. The proposed amendment to the amendment simply sets out how he shall be elected, how long he shall serve and whether or not he shall be a delegate. That is the ruling of the Chair. If you care to appeal the ruling of the Chair I will be very glad to put the question, the Chair is quite confident that his ruling is correct.

DR. CANTEY: If this gentlemen is not a Member of the House of Delegates, would he have a power to vote in case of a tie?

THE CHAIR: As a matter of fact the Speaker of the House is not supposed to have a vote at all, does that answer your question?

DR. CANTEL: Yes.

THE CHAIR: Is there any further discussion?

DR. HEYWARD: The question was explained by Dr. Wyatt as to why there seemed a necessity of a speaker of the House. I was just wondering if in a way that is a slap in the face of the presidents who have gone past. As far as I could tell the business of this house has been running pretty smoothly and we have had a number of presidents who presided pretty well, a few mistakes have been made but not many. And, back to the old theme, you are taking all activities away from the officers and putting them in the hands of people to run them perhaps more expeditiously but it is taking one of the duties of the President away. I am opposed to it.

DR. CHAS. WYATT: This thing was not proposed as a slap in anybody's face. I thought I had stressed that when I made my talk, it is merely proposing to give some aid to the President. This job of the President of the State Association is a job of work and if a man stays in there and works, God knows he needs a little help.

DR. W. R. WALLACE: Of course, Dr. Wyatt has presented his side of the subject mighty well but I don't think that all of his argument is in favor of a speaker of the House. He spoke of the President needing aid. I think when we elect a president he has on his mind certain projects which he thinks would be of advantage to this Association and I don't think they could be put in effect as effectually by a Speaker of the House as they can by the president, himself. We have a fine example of that here. We have Dr. Guess, who has inaugurated a new scheme, which is expediting our business, and I don't believe any Speaker of the House could carry on this program as well as the president, himself. Furthermore, I think when any man is elected president-elect of the South Carolina Medical Association and has a whole year to observe and to look up to Robert's Rules of Order and Parliamentary Law, I think he should be able to preside and to preside without too much slack or confusion,—so I believe we are detracting from the respect and somewhat from the honor of the president. I like, when the president goes in here for him to give

us his very best and which, I think, they all try to do, and if we get into any parliamentary snarls it is always very easy to appeal, or for someone in the House to appeal from the ruling of the presiding officer. I do not believe in a small association of from 65 to 90 members a Speaker is altogether essential. I know it is essential in the A. M. A. and in some of the larger associations. I fail to see why a small association, as ours, should require a Speaker of the House.

DR. GOLDSMITH: Members of the House of Delegates. As I see it, as Dr. Wyatt has said, this is not intended to be a slap at any former or any future president. However, there are times when the president is not so conversant with Parliamentary Law and a Speaker of the House must of necessity be of that type. Any of you who have attended any meetings that are presided over by a Speaker of the House know that they move along rather smoothly, and, in case the president has anything he particularly wants brought up he makes his report and suggestions to the Speaker of the House. I have recently attended two meetings that were presided over by a Speaker of the House, the Academy of General Practice, in Atlantic City, and the Association of American Physicians and Surgeons, and the wishes and desires of the president were carried on through the speaker of the house. It is a forward step, it would certainly give the president a lot of help that they need and would not detract in any way from his honorary or his specific duties. I would like to see this particular motion go through.

THE CHAIR: Is there any further discussion, gentlemen?

DR. BROWNING: The Edisto Society discussed this and they instructed their delegates to vote against it, therefore we will vote against it.

THE CHAIR: The order of vote will be this, first, the question will be on the amendment to the amendment, Dr. Wilson's amendment; then will be the question on the amendment to the Constitution, as amended or without the amendment, provided you do not accept the amendment.

Those in favor of adopting the amendment proposed by Dr. Wilson, which would define, limit somewhat the proposed speaker, make it known by saying "aye." (Many voted "aye.") Opposed "No" (There were a few "noes") The "ayes" have it and the amendment to the amendment is adopted.

Now, gentlemen, those of you who are in favor of adopting the amendment to the Constitution, as amended by Dr. Robert Wilson's proposal, make it known by saying "aye." (Some voted "aye" and when the "noes" were called for some voted "no.") There was a division.

Those in favor of adopting this amendment make it known by rising. (Thirty-three stood.) Those opposing the adopting of this amendment make it known by standing. (Twenty-seven stood.)

THE CHAIR: Article 13 with respect to amendment states that the Constitution may be amended by a two-thirds vote of the delegates present. Two-thirds of the Delegates did not vote in favor of the proposal and therefore the proposal to have a Speaker of the House is lost.

The Reference Committee on Constitution and By-Laws will take that into consideration with those changes in the By-Laws which have been proposed.

DR. LYNCH: It is my understanding that is not a matter of reference to the Reference Committee at all.

THE CHAIR: Any of the proposals that have to do or have any bearing on the Speaker of the House have been deleted from Dr. Price's Committee's report, that

will require some rewriting and deletion in connection with the report of the Committee on Constitution and By-Laws.

SPECIAL ORDER—12:30 P. M. Annual Meeting of the Corporation, S. C. Medical Care Plan.

(The House of Delegates rose and sat immediately as the Corporation of the S. C. Medical Care plan.

(At the close of the business of the meeting the Corporation rose and sat immediately as the House of Delegates of the S. C. Medical Association.)

THE CHAIR: We will resume under the head of unfinished business. Last year a committee, headed by Dr. Roderick MacDonald brought in a proposal that the S. C. Medical Association provide and set up a Grievance Committee. He outlined the organization of the committee and proposed regulations for its operation. It was complicated, and it was the voice of the House of Delegates that this rest on the table and be brought up again at this time. That was not necessary under parliamentary procedure, because actually it was an amendment to the By-Laws and not to the Constitution, but the House perhaps very wisely did that. That is being called off the table now and if for consideration. It has been suggested by several individuals that the better way to handle this would be to break the question down in two parts. First do you want a State Grievance Committee, and secondly, if you do want a State Grievance Committee that the MacDonald report be referred to the Committee on Constitution and By-Laws with reference, instructing them to bring in a report tomorrow morning as to procedures, personnel of the committee, etc., if there is no objection.

And, if there is objection, don't hesitate to say so. If there is no objection the House will first consider this question: Do we want a Grievance Committee?

DR. GERTRUDE R. HOLMES: I move that the House of Delegates set up in the State of S. C. Medical Association a Grievance Committee. (This was seconded by Dr. William H. Folk, of Spartanburg.)

THE CHAIR: Do you care to discuss it, are you ready for the question? All in favor of establishing a Grievance Committee by the South Carolina Medical Association make it known by saying "aye." All opposed "no." The Ayes have it and it is so ordered. So we will set up a committee on Grievance within the state society.

So, the Chair will refer the MacDonald Report to the Committee on Constitution and By-Laws, and they will bring in a report on that tomorrow as a part of their report.

Is there any other unfinished business?

(There was none)

THE CHAIR: Then we will move under the head of NEW BUSINESS.

DR. GOLDSMITH: I wish to propose this for an amendment to the Constitution, Chapter IX—"That, a Speaker of the House of Delegates shall be elected annually. Such Speaker of the House of Delegates shall be a member of The Association versed in parliamentary law, but need not be a member of the House of Delegates. He shall preside at all meetings of the House of Delegates until his successor has been elected."

THE CHAIR: This is a proposed amendment to the Constitution and under the law will lie on the table one year and will then be brought up for action.

Is there any further NEW BUSINESS?

DR. CHAS. N. WYATT: Mr. President, this is a proposed amendment to the By-Laws, which shall read as follows: "The number of *The Journal*, pub-

lished immediately prior to the annual meetings of the Association shall be the handbook of the convention. In it shall be printed the agenda of the meeting of the House of Delegates, the program of the scientific session, reports of all officers and of all standing and special committees, and such other data as is ordinarily printed in convention handbooks and official programs. It shall be the duty of the business manager to assemble the above material and to transmit it to the Editor in ample time for editing and arranging before the press deadline."

THE CHAIR: This is a proposed amendment to the By-Laws.

DR. WESTON COOK: I wish to present a resolution for consideration by the proper committee and say just a word in explanation of it. All here, I am certain, are aware of the retirement benefits available to employees of various corporations whereby a certain percent of their income goes into a certain fund and is matched by the corporation and later comes back in the form of retirement benefits and income tax is not paid as it is going in but when it is coming back, when the amount to be paid will be smaller. The American Medical Association and the American Bar Association have recognized that this represents quite a tax inequity for doctors and other self-employed groups. They have stimulated legislation before the Congress to correct this. There was introduced last year and pending before the next session the Keogh-Reed Bill which will in effect remove this inequity. The Chairman of the Special Committee for the American Bar Association has stated that some such legislation stands a fair chance of passing Congress if it is backed by all professional groups. This information was presented at Columbia to the Medical Society at the April meeting and the delegates were instructed to bring this before this meeting, we hope for favorable consideration.

"Whereas there now appears to exist a tax inequity for physicians and other self employed professional groups, with particular reference to the opportunity for retirement benefits.

"And whereas there is now pending before the National Congress a Bill H. R. 4473, known as the Keogh-Reed Bill that will remove this inequity.

"Therefore be it resolved that the House of Delegates, South Carolina Medical Association heartily endorses this legislation and urges that our representatives in the National Congress give it their earnest consideration.

"A Copy of this resolution shall be sent to each of our Senators and member of the House of Representatives and to each local medical society in the state."

THE CHAIR: If there is no objection we will consider this resolution at this time. I don't believe it is necessary to refer it to a reference committee, we are familiar with it, more or less.

DR. JOE CAIN: I move the adoption of that resolution. (This motion was seconded by Dr. Goldsmith; discussion was called for, there was none; a vote was taken and the motion was unanimously carried.)

THE CHAIR: The secretary is instructed to carry out the provision of the resolution in regard to its distribution to our representatives in Congress.

Is there any further NEW BUSINESS?

DR. F. E. KREDEL: Perhaps some other means can be made to correct the situation that I bring before you so that one of the outstanding physical therapists will not be legislated out of business, but I bring you this resolution:

"Whereas, State Law RH25 H1760 approved February 29, 1952 required the licensing of Physical Therapists effective January 1, 1953; and

Whereas, membership in or eligibility for the American Physical Therapy Association is a requirement for licensure; and

Whereas, for example, it would seem that an outstanding practitioner of physical therapy for the past twelve years in Charleston will be debarred, her credentials having been seized by the Nazis before she escaped.

Resolved, that the House of Delegates is of the opinion that a physical therapist who has practiced in South Carolina five years or more before this Act and who is recognized as having the equivalent in training and competence for the requirements of the Act by the local Medical Society and the State Examining Board for Physical Therapists shall be eligible for license."

DR. WYMAN KING: I move the adoption of the resolution.

THE CHAIR: What action are you proposing, Dr. Kredel?

DR. F. E. KREDEL: I think it should be referred to the Committee on Legislation this afternoon.

THE CHAIR: All right, it will be so referred, to the Committee on Legislation, Public Health and Public Policy.

Is there any further *New Business*?

THE CHAIR: There is one matter to be cleared, trying not to be autocratic, Article IX, Section 3, of the Constitution, the section relating to the election of officers, says "The officers of this Association shall be elected by the House of Delegates on the first day of the Annual Meeting of the House of Delegates." In your call meeting on December 8th you authorized this change in set-up. It is not customary to suspend the Constitution, as a matter of fact the Constitution should not be suspended, but the Chair would like the House to suspend this particular item of the Constitution so that the election of Officers shall be the last item of business which shall prevail.

Will someone move to suspend this particular item of the Constitution, or shall we go into the election of officers?

DR. WYMAN KING: Mr. President, I move this Section be suspended. (This motion was seconded by Dr. Cantey; there was no discussion, and the motion was carried.)

THE CHAIR: We have suspended the Constitution.

Don't forget the meetings of the Reference Committees. The House of Delegates convenes in the morning at 9:00 o'clock.

WEDNESDAY—MAY 14, 1952—MEETING OF HOUSE OF DELEGATES

Presiding—President J. Decherd Guess, M. D.

Call to Order—9:15 A. M.

THE CHAIR: I have a few preliminary things I want to say. We have just gotten a letter from Mrs. Jeff Chapman, Dr. Chapman is councilor from the 1st district, he is seriously sick at home and has been sick a month. He has sent his good wishes to the House of Delegates and his regret for his inability to be here. If there is no objection I will instruct the Secretary to send Dr. Chapman a telegram of regrets over his absence and in appreciation of his thoughts of this body and its business.

The second announcement is even more sad than that of Dr. Chapman's illness, the newspapers carry an account of Dr. Allen Huggins Johnson's death of Hemingway. He died late last night of a heart attack

at the age of forty-one. That makes the forty-third death from our ranks since the last meeting of the House of Delegates.

We have with us today a fraternal delegate from the North Carolina State Medical Association, Dr. Mullan. (Dr. C. G. Millham, of Hamlet, N. C., came forward and was presented and brought the following greeting from his State Association.)

DR. C. G. MILLHAM: The President of North Carolina Medical Association's House of Delegates sends greetings to the members of the South Carolina Medical Association House of Delegates. I have only been here a few minutes but I find out your problems are very much the same as ours in North Carolina. I want to state that I am highly honored being selected as the delegate to South Carolina and am looking forward to listening with a lot of interest to the papers, and I hope to take back a great many useful and helpful suggestions, thank you.

THE CHAIR: Dr. Millham, as fraternal delegate, we extend to you the privilege of the floor not only in the business session today but in the scientific session today and tomorrow and hope you will avail yourself of the privilege and instruct us in some of the things a physician of your standing has to offer.

DR. WM. WESTON, JR.: A good many of the men have expressed a desire to form a S. C. Medical Golfers' Association and we are now undertaking this, and until Dr. Harry Davis from Sumter arrives, Dr. Jim Snyder from Sumter has offered to assist him and we have a list at the back of the room, someone back there will take names so that we can go ahead with this and have an annual convention at this time. We hope that doctors from the various places in the state will be appointed so that we can find out how many and the proper handicap.

THE CHAIR: We will take up the reference committee reports. There has been a little disturbance in the minds of the delegates as to how we are going to handle the reports of the reference committees. I want to quiet any fears, the order will be this: The Chairman of the Reference Committee, presenting the report will move the adoption of the report. No doubt somebody will be kind enough to second that motion to adopt; then the motion will be before the House for adoption, for rejection, for amendment by deletion, for amendment by addition, and for amendment by substitution, and adequate time will be allowed for you to discuss these things. However, I do want to ask this, the election of officers is absolutely essential to the adjournment of this meeting, it has been made a Special Order for 12:30 P. M., and I hope we can get through business and go into the election at that time.

REPORT—The first reference committee report we will have is the report from the Council acting as Reference Committee on FINANCE, and at the same time I will ask Chairman of Council to make any other report from Council while he is on his feet, Dr. Mayer.

(Dr. Mayer read the report of the Reference Committee)

The committee, acting as the Reference Committee on Finance, considered the following:

1. Request of the Committee on Infant Mortality for \$150.00 to carry on their activities for the coming year. The work of this committee was reviewed and appears to be vital and important. It is recommended that the request for \$150.00 be authorized.

2. Request of the Committee on Historical Medicine for \$100.00 per year to carry on their work. The importance and value of preserving historical data of the

Association is well recognized, and this committee recommends that the sum of \$100.00 per year be authorized.

3. The amendment to the By-Laws, offered by Dr. Charles N. Wyatt, that the last issue of the Journal appearing before the annual meeting carry the agenda, committee reports, program, etc., and be in effect a handbook of the meeting, was carefully considered by the committee. The Editor was consulted and after due deliberation it was believed that the intent of the amendment could not be satisfactorily carried out due to the lag in time necessary between collecting and assembling the data and distribution of the Journal to the subscribers.

The committee disapproves the proposed amendment.

4. I move on behalf of this committee the adoption of this report by the House of Delegates.

DR. MAYER: Mr. President, I move the adoption of this report by the House of Delegates. (Dr. Lynch seconded the motion; there was no discussion, the question was put, and carried unanimously.)

THE CHAIR: The report is adopted.

Dr. Mayer, was there anything from Council?

(Dr. Mayer stated there was nothing further.)

THE CHAIR: The next is the report of the Reference Committee on Constitution and By-Laws, Dr. Kenneth Lynch.

DR. KENNETH LYNCH: Inasmuch as the only amendment to the Constitution was acted upon by the House of Delegates, thereby removing it from consideration by the committee, there is no proposed change in the Constitution.

The matters considered by the Committee relate only to the By-Laws and to recommendations outside of the By-Laws which relate to changes in them, so as to make clarifications of procedure. And from the Action of the House to establish a Grievance Committee and from the report of the Special Committee on negotiations with the negro doctors, from consideration of those matters which constituted the territory of reference to this committee, at this time the Committee proposes the following changes in the By-Laws.

REPORT OF THE REFERENCE COMMITTEE ON CONSTITUTION & BY-LAWS

From consideration of the matters referred to it the Committee recommends the following changes in the By-Laws:

Chapter I. Sec. 4 to be changed to read:

Section 4. Any physician who has been a member in good standing for forty consecutive years automatically shall become an Honorary Member of the Association. Any physician who has been a member in good standing for twenty-five consecutive years shall, upon retirement from active practice, be eligible for Honorary Membership in the Association, provided his society so recommends and provided further that his application is approved by Council. Honorary Members shall be entitled to all the privileges of members of the Association but shall be exempt from the payment of annual dues.

Chapter I, Sec. 5 to be changed to read:

Section 5. Distinguished medical men, living outside of the state, and those living in the state who are no longer connected with the practice or teaching of medicine, may be elected Honorary Fellows of the Association by an affirmative vote of three-fourths of the members of the House of Delegates voting. Honorary Fellows are exempt from the payment of dues but shall have all the privileges of membership except the right to vote and to hold office.

Chapter I, Section 6 to be changed to read:

Section 6. Physicians who are members of other state medical associations may, upon the invitation of the President or Secretary of this Association, become guests of the Association and as such, they shall be given the privilege of participating in all of the scientific work of the sessions. Special badges shall be provided for them by the Secretary.

Chapter IV, Section 13 to be deleted.

Chapter V, Section 1—to be changed to read as follows:

Section 1. Officers of the Association shall be elected by the House of Delegates as its last order of business at the annual session. All elections shall be by ballot, a majority of the votes cast being necessary to elect. Where there are three or more nominees and no nominee receives a majority of the votes cast, the nominee receiving the lowest number of votes shall be eliminated from consideration, and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of the votes cast.

Chapter V, A NEW SECTION—Section 2.

Section 2. Nominations for office, except that for the office of Treasurer, shall be made from the floor. Nominations for Treasurer shall be made by Council, sitting as the Finance Committee of the Association.

That Old Section 2 to be renumbered Section 3.

That present Section 3 become Section 4 and be changed to read as follows:

Section 4. The Council shall elect an Executive Secretary, whose duties shall be determined and salary fixed by the Council.

Chapter VI, Section 2—to be changed to read as follows:

Section 2. The Vice-President shall assist the President in the discharge of his duties, and shall succeed the President in office IN CASE OF DEATH, RESIGNATION, OR REMOVAL OF LEGAL RESIDENCE FROM THE STATE.

Chapter VI, Section 4—to have the following new sentence added:

He shall make an annual report to the House of Delegates.

Chapter VI, Section 5—to have the following new sentence inserted following the first paragraph.

He shall make an annual report to the Council.

AND—the last paragraph shall be changed as follows:

"At the discretion of Council, any of the duties as outlined above may be transferred from the Executive Secretary to the Secretary of the Association."

Chapter VI, Section 6—The first sentence shall be changed as follows:

Section 6. The Treasurer shall give bond in a sum to be determined by Council. He shall demand and receive all funds due the Association, together with bequests. He shall pay money out of the treasury in accordance with instructions from the Council, or House of Delegates. He shall submit his accounts to a certified accountant, approved by Council for an annual audit, and he shall annually render a report and an account of the state of the funds in his control to the Council. The amount of his salary shall be fixed by the council.

Chapter VII, Section 1—The last sentence of the first paragraph shall be changed to read as follows:

"At its first meeting after the adjournment of the House of Delegates, it shall elect a Chairman, Vice-Chairman, and a Clerk, who in the absence of the Secretary of the Association, shall keep a record of its proceedings."

AND—the last sentence of the second paragraph shall be changed to read:

Seven members shall constitute a quorum.

Chapter VII, Section 5, to be changed to read as follows:

Section 5. The Council shall receive the annual audit of the Treasurer and the annual report of the Executive Secretary, the Editor, and other agents of the Association and shall present a statement of the same in its annual report to the House of Delegates. At the annual meeting, the Council shall adopt a financial budget for the coming year.

Chapter VIII, Section 1, to be changed to read as follows:

Section 1. Classification. The following classes of committees are hereby provided:

- a. Standing committees
- b. Reference committees
- c. Special committees

Section 2, A NEW SECTION—to read as follows:

Section 2. Qualifications of committee members. Any member or honorary member of the Association is eligible to serve on a standing committee. Membership on a reference committee is restricted to members of the House of Delegates. Members of committees who are not members of the House of Delegates may present their reports in person to the House and may participate in debate thereon but shall not be entitled to vote.

Chapter VIII, Section 3—A NEW SECTION to read as follows:

Section 3. The following are the standing committees of the House of Delegates:

- (1) Committee on Scientific Program
- (2) Committee on Legislation and Public Relations
- (3) Committee on Public Health
- (4) Memorial Committee
- (5) Committee on Maternal Welfare
- (6) Committee on Infant Mortality
- (7) Committee on Cancer
- and adding a new Committee
- (8) Committee on Grievances

Present Section 2—to be renumbered SECTION 4 and to be changed to read as follows:

Section 4. The Committee on Scientific Program shall consist of three members, together with the President and Secretary, ex officio. It shall determine the character and scope of the scientific program of the general sessions of the Association and select the speakers, subject to the instructions of the House of Delegates or Council. Thirty days prior to each annual session it shall prepare and issue the official program of the meeting.

Present Section 3—to be renumbered Section 5 to be changed to read as follows:

Section 5. The committee on Legislation and Public Relations shall consist of five members, and the President, President-Elect, and Secretary, ex officio. The Executive Secretary of the Association shall serve as executive secretary of this committee. It shall represent this Association, etc.

Present Section 4—to be renumbered SECTION 6, and to be changed to read as follows:

Section 6. The Committee on Public Health shall consist of five members none of whom shall be, etc.

Present Section 5—TO BE DELETED.

Present Section 6—to be renumbered SECTION 7.

Present Section 7—TO BE DELETED.

A NEW SECTION 9 to be added to read as follows:

(Added) Section 9. The Committee on Infant Mortality shall be appointed by the President and shall consist of the following: two general practitioners who shall be nominated by the South Carolina Chapter of the Academy of General Practice, one for a one-year term and one for a two-year term; one obstetrician who shall be nominated by the South Carolina Society of Obstetrics and Gynecology, for a term of two years, and two pediatricians who shall be nominated by the South Carolina Pediatric Society, one for a one-year term and one for a two-year term. The terms of all members after the initial terms as herein provided, shall be two years. All members of the Committee shall be members of the Association. The Chairman shall be a pediatrician and shall be appointed by the President, upon recommendation of the South Carolina Pediatric Society.

A NEW SECTION 10—To be added to read as follows:

The Committee on Cancer shall be appointed by the President and shall be composed of nine members, each of whom shall be appointed for a term of three years. It shall be the duty of this committee to study and advise the Association with regard to the diagnosis, treatment and care of cancer patients. It shall also serve as an advisory committee to the S. C. State Board of Health in matters pertaining to cancer.

A NEW SECTION to be numbered SECTION 11 and to read as follows:

"The Committee on Grievances shall be composed of nine members, one from each medical district. These shall be elected by the House of Delegates from a slate of eighteen (18) members submitted by Council, such list to include two (2) members from each medical district, but no two members from any one county. The terms of these members shall be three (3) years and shall coincide with the terms of the councilors from the corresponding districts. No member of the committee shall serve more than two (2) successive terms.

The Committee shall meet twice a year and on call of the Chairman at its annual meeting it shall elect its own officers.

The committee shall receive and investigate complaints concerning professional conduct and ethical deportment of members of the association and shall attempt amicable adjustment. Where disciplinary action is indicated all evidence shall be submitted to council with recommendations for action.

The Committee shall develop its method of procedure and rules of action subject to the approval of council.

Present Section 9—is renumbered SECTION 12 and to be changed to read as follows:

Section 12. Members shall be appointed to Standing Committees by the President, unless otherwise provided for in these By-Laws.

Present Section 10—is to be renumbered SECTION 13.

Present Section 11—is to be renumbered SECTION 14.

Present Section 12—is to be renumbered SECTION 15.

A NEW SECTION 16—is to be added as follows:
Reference Committees

(a) Appointment. The President shall appoint from the members of the House the committees enumerated in this section and such additional committees as the House may approve. Each committee shall consist of five members, a chairman to be designated by the President. These committees shall serve only during the session at which they are appointed.

(b) References. All resolutions presented to the House of Delegates shall be referred to appropriate reference committees for consideration and report. No resolution presented to the House of Delegates may be voted upon without being referred to a Reference Committee unless (a) it is so ordered by a two-thirds vote of the Delegates present, (b) it is presented on the last day of the session by Council.

(c) Hearings and recommendations. Each committee shall convene as soon as possible after the first recess of the meeting of the House, or during a meeting if necessary. It shall conduct open hearings on the business referred to it and any member of the House of Delegates and of the Association is privileged to present his views upon the matter under consideration. Following the hearing, the committee shall go into executive session and prepare its report. The final report shall be presented to the House of Delegates by the chairman of the Reference Committee upon the call of the President.

(d) Enumeration. The following reference committees are hereby provided:

(1) Reference Committee on Reports of Council and Officers, to which these reports shall be referred.

(2) Reference Committee on Legislation and Public Relations, to which shall be referred all matters relating to state and national legislation, and to the public relations of the Association.

(3) Reference Committee on Public and Industrial Health, to which shall be referred all matters relating to public health, industrial health, Workmen's Compensation and public welfare.

(4) Reference Committee on Amendments to the Constitution and By-Laws, to which shall be referred all proposed amendments to the Constitution and By-Laws.

(5) Reference Committee on Credentials, to which shall be referred all questions regarding registration and credentials of delegates.

(6) Reference Committee on Insurance, Blue Cross and Blue Shield, to which shall be referred all matters pertaining to insurance, Blue Cross and Blue Shield.

(7) Reference Committee on Miscellaneous Business, to which shall be referred all other business.

Chapter IX, Section 4—Delete all of Section 4 except as follows:

Section 4. Each county society shall judge of the qualifications of its members.

Section 8—Delete the last part of Section 8 which reads "and toward increasing the membership until it embraces every qualified white physician in the county."

ADD NEW SECTION 13—to read as follows:

Section 13. When a component society acts as host to the general meeting of the Association, the component society shall appoint a committee on local arrangements to collaborate with the Executive Secretary in making arrangements for the meeting.

Chapter X—Add NEW SECTION 3, to read as follows:

Section 3. The expenses of all meetings of the Association shall be paid by the Association, and the Treasurer is authorized to pay such expenses out of Association funds, after approval by Council.

In addition to the changes recommended in the by-laws which are substantially in accord with the report of the Special Committee on Revision of Constitution and By-Laws, the Committee recommends adoption of a course of procedure by the Committee on Grievances as follows:

All complaints should be filed with the Chairman. He should submit a specific complaint to three members of the Committee, none of whom shall be from the same medical district as the physician named in the complaint. These three (3) members should obtain all pertinent information referable to the complaint, discuss the matter with both parties involved, hold hearings, if necessary, and attempt amicable adjustment. If such an adjustment can not be reached, the matter shall be referred to the full committee for further consideration and for final action.

A brief record of all such cases, whether of a subcommittee or of the Committee as a whole, should be filed with the Chairman. Such reports should be confidential information of the Committee, and of Council, when recommendations for discipline are made to Council, but they should not be made public except by a majority vote of both the Committee and Council.

A brief annual report of activities, omitting the names of persons involved, shall be made by the Chairman of the Committee to Council.

SUPPLEMENTARY REPORT

In the category of recommendations, rather than changes in the by-laws, the reference committee also recommends that county societies be requested to give serious consideration to the admission of qualified negro doctors of medicine to their membership, and suggest that negro physicians be invited to attend the scientific sessions of County and District societies, and of the state association.

DR. LYNCH: Mr. President, I move you the adoption of this report of the Reference Committee on Constitution and By-Laws.

THE CHAIR: Thank you very much, and your committee, for this excellent and careful study of the proposed revision of the Constitution.

Gentlemen, you will understand that the Special Committee on Revision of Constitution and By-Laws, yesterday placed before you, and they were immediately laid on the table for consideration next year, certain revisions in the Constitution. Those proposed revisions do not come up for consideration this morning at all. Dr. Lynch brought that out in his remarks. I want to stress that, they are before the house but lying on the table to await action next year.

Our consideration at this time is purely on proposed revision in the By-Laws as recommended by the Special Committee on Revision of Constitution and By-Laws and approved or changes by this Reference Committee. It has been moved by Dr. Lynch, Chairman of the Reference Committee, that his report be adopted as a whole. It would be very fine if we could act on that motion for adoption but there are matters that are controversial in that report, and I am afraid that if we attempted to act on those changes, as a whole, it might lead into a plethora of discussion.

However, that is for you to decide, so the question now is "shall we adopt this report as a whole?" It has been moved that we do so.

(The motion of Dr. Lynch was seconded by Dr. Joe Cain)

THE CHAIR: Is there any discussion?

DR. WM. WESTON, SR.: Mr. President and members of the House of Delegates, I have not heard any suggestion for certain changes that have been made in the denomination of the office of General Manager and Counsel, it seems to me that if the English language is strictly interpreted that to change that title to "Executive Secretary" puts the medical man, although this is a Medical Association, in an extraordinary position.

THE CHAIR: Let's confine this discussion to whether we accept the report as a whole or take it up Section by Section. If we take it up section by section then when that particular matter comes up, you will be recognized.

DR. WESTON: I thought this was introductory remarks. I want to state that I am opposed to that, instead of the wording "Executive Secretary" substitute the former title, otherwise, the report, so far as I am concerned is acceptable.

THE CHAIR: The question before the house is shall we accept this report as presented as a whole or shall we not.

Is there any further discussion?

(The question was called for.)

THE CHAIR: Those in favor of accepting the report as a whole, make it known by saying "aye." Then the contrary minded were asked to vote "no." (There was a division of the vote.) A two-thirds vote is required for this. The House will stand for division. Those in favor of accepting the report as a whole, make it known by standing.

(48—forty-eight stood)

Those opposed to accepting the report of the Reference Committee as a whole, make it known by standing.

(12—twelve stood.)

THE CHAIR: It required a two-thirds vote to adopt, we have 48 against 12, the report of the Reference Committee is adopted by a three-fourths vote, more than is required. THEREFORE, the report is adopted and these changes in the By-Laws are in effect as from now.

DR. JULIAN PRICE: It has been the custom whenever we revise the Constitution and By-Laws to have these printed immediately and distributed, but—in view of the fact that certain changes in the Constitution have been proposed and will have to wait until next year, I move, sir, we defer the printing of the Constitution and By-Laws until after next year's session and that mimeographed copies be made of the change in the By-Laws and sent to all Members of the House. (This motion was seconded.)

THE CHAIR: You have heard the motion, those in favor of deferring the printing of the new By-Laws, as they have been amended, until after action has been taken on the proposed changes in the Constitution, signify by saying "aye." (The motion was carried unanimously.)

THE CHAIR: Dr. Lynch, and members of your Committee, I want to say to you that this vote adopting your recommendations for proposed changes in the By-Laws is a vote of confidence in not only your ability, and your earnestness, but the zeal with which you investigated this matter. It is also an indication of how democratic processes can proceed through a method of Reference Committees. Many of you, who were interested in these proposed changes appeared before this committee yesterday and made it possible for this committee to reflect the opinion of the House.

THE CHAIR: The next report is that of the Reference Committee on Medical Economics, Care of the Indigent, and Public Relations, Dr. V. W. Brabham, Jr.

THE REFERENCE COMMITTEE ON MEDICAL ECONOMICS, CARE OF THE INDIGENT, AND PUBLIC RELATIONS

has reviewed reports by the following Committees: I—The Industrial Fee Schedule Committee—

First we wish to commend this committee for the continuous work that is being done. This reference

committee recommends to the House of Delegates that it approve the suggested changes contained in the report of the Industrial Fee Schedule Committee.

2—The Report of the South Carolina Medical Advisory Committee To Selective Service is passed to the House of Delegates as Information. The Chairman and his committee have done outstanding work on a responsible job affecting the entire state.

We would like to call particular attention to the fact that every physician, classified 1-A who received part or all of his medical education at government expense, who has had less than 21 months prior active service, already has either entered service or has applied for commission.

Further, your attention is called to an extraordinary, rare phenomena, namely, that your Selective Service Advisory Committee has returned to the Federal Treasury \$150 out of an allotment of \$400 by Washington Headquarters of selective service for a statewide committee meeting.

3—The Committee on Rural Health—The reference committee approves in principle the splendid objectives contained in this report. The attention of the House of Delegates is called to the fact that scholarships for medical students agreeing to practice in rural communities are currently in effect from state appropriated funds. It is recommended that the House of Delegates continue to support this policy.

4—The Committee on the Care of the Indigent—It is recommended that the suggestion of the Chairman, Dr. John K. Webb, that this committee be dissolved to be reactivated at a more appropriate time be accepted. It does not appear opportune at this time to embark on a program of this magnitude. We are aware of the tremendous effort expended by Dr. Webb and his committee in studying this problem, for which he has the thanks of the association.

DR. BRABHAM: There are several recommendations contained in this Report. I move the adoption of this entire report by the House of Delegates.

(This motion was seconded)—by Dr. Robert Wilson.

THE CHAIR: You have heard the Report of the Reference Committee on Medical Economics, Care of the Indigent, and Public Relations, and its adoption has been moved and seconded. (Discussion was called for, there was none; a vote was taken and the motion was unanimously passed.)

THE CHAIR: The report of the Reference Committee on Legislation, Public Health and Public Policy, Dr. W. R. Wallace.

DR. W. R. WALLACE: Our Reference Committee received quite a number of reports, but I shall take them up in no particular order, but just as I have them before me. We appreciate the interest and help the members of the Association gave us in consulting with us on these reports.

The first I have before me here is a report or request from Dr. Kredel, acting for the members from Charleston.

"We recommend that the House of Delegates is of the opinion that a physical therapist who has practiced in South Carolina five years or more before the passage State Law RH-25 H 1760, approved Feb. 29, 1952, and is recognized and endorsed by the local medical society and the State Examining Board for Physical Therapists shall be eligible for license."

We recommend that this resolution be passed so that this particular person and any others who might fall in this qualification could receive a license and become regular licensed members of this organization. Mr. President, I MOVE THE PASSAGE of that resolution.

(This motion was seconded by Dr. Adcock, of Columbia.)

THE CHAIR: Is there any discussion?

MEMBER: Mr. President, I believe that this motion, if it were changed to read "TEN" years, instead of "FIVE" years, they would have no objection whatever.

THE CHAIR: It has been moved that the resolution offered by the Reference Committee be amended to change the length of practice from FIVE TO TEN years, is there a second to that amendment? (The amendment was seconded by Dr. Thomas R. Gaines, of Anderson.) (no discussion) (A vote was taken on the amendment and it was passed with only one vote against it.)

(A vote was then taken on the motion of Dr. Wallace, as amended, and this motion was carried.)

THE CHAIR: The resolution is adopted as amended.

DR. WALLACE: (Continuing.)

"We recommend that the House of Delegates commend the Legislative and Public Policy Committee, of which Dr. William C. Cantey is Chairman, for their fine work in following through the Bills introduced into the State Legislature, during the past year, that affect the Medical Profession. Also the following:

1—WHEREAS the number of Bills in the State Legislature affecting the Medical Profession has increased greatly, and

WHEREAS, we believe this information should reach the County Medical Society level, we recommend that the House of Delegates instruct the president of each component society to appoint one or more members to receive and disseminate information in respect to legislative matter:

2—That this information be secured by the Executive Secretary and transmitted to those designated in each county, weekly, during the legislative session. These appointees will be expected to contact and advise the members of the county delegation on matters pertaining to the Medical Profession, when deemed necessary.

Mr. President, I move the adoption of this resolution.

THE CHAIR: You have heard the resolution and its adoption has been moved, is there a second?

(The motion was seconded by Drs. Lynch and Browning; there was no discussion; a vote was taken and was unanimously passed.)

THE CHAIR: The secretary is instructed to notify the presidents of the component societies of this resolution and the Executive Secretary of it, also, because his office is supposed to furnish the data to the County Societies.

DR. WALLACE: Regarding the report of the Executive Committee, State Board of Health, I disqualified myself on that report and the other members of the committee studied the report and made the following recommendations:

We recommend the Adoption of the suggestions as listed in the last paragraph of Report of the executive committee of the State Board of Health, as follows:

"It is our opinion that the affairs of the Board of Health could be greatly improved by the following amendments to the present act. (1) Staggering the election of the members of the Executive Committee (2) Shortening the terms of office to five years (3) Adding the Chairman of the Medical Affairs Committee of the Senate and Chairman of the Military, Public and Municipal Affairs Committee of the House (Medical Affairs) instead of the Attorney General and Comptroller General (4) Obtaining the whole-

hearted interest and support of the Medical and allied professions, *by making an overall study of public health in South Carolina in its broad scope and make suggestions to the Executive Committee when deemed advisable.*

DR. WALLACE: Acting for the Committee I move the passage of that. (This motion was seconded by Dr. Weston, Jr., there was no discussion; a vote was taken and the motion was unanimously passed.)

DR. JOE CAIN: Last December, if I remember, this group voted to submit a resolution to the State General Assembly, which if passed would have done away with our present Executive Committee of the Board of Health, as we know it. After passing the House of Representatives that resolution or bill was killed in the Senate by virtue of the fact that it was never brought out of Committee.

It seems to me that leaves our Executive Committee in a rather embarrassing position, it is in the position of having to serve a body which has, in effect, voted to kill it.

I would like to make a motion to this House today, in two parts—(1) that we give our Executive Committee a vote of confidence (2) that we instruct our Public Health Committee, which is a standing Committee of the Association, to communicate with physicians over the state ascertaining whether or not there are any complaints concerning the running of the State Board of Health, and if so, communicate the information to the Executive Committee so that, if possible, these may be remedied.

(The motion of Dr. Cain was seconded by Dr. Lynch and numerous others; there was discussion as follows:

DR. HAYNE: I would like to state that the Comptroller General was there to advise in matters pertaining to finance and that the Attorney General was put there to advise in matters pertaining to the law,—as I see it, if we have a Chairman of Finance and a Chairman of Ways and Means, they can only advise as to one thing, that is how much money will they give us.

THE CHAIR: Under the present set-up money is more important than law.

Is there any further discussion?

DR. J. L. HUGHES a member of the Reference Committee—

It was the intent of the Committee, in our last statement we added to the recommendation of the report of the Executive Board that such a study should be made with the Executive Committee of the State Board of Health and they should be commended on their work, and whatever information could be secured should be given to the physicians of the state. There was a lot of criticism last year, and the Board I was on didn't have much to do but take the criticisms and treat them the best we could and we found the most were small parts of the big question. We added a phrase, that a study of this be made and this information be given to the physicians, which I think was the intent of Dr. Cain's motion.

THE CHAIR: Gentlemen, no doubt the Chairman of the Reference Committee was a little too modest to stress that, I thank Dr. Hughes for stressing it.

Is there any further discussion? (There was none.)

Gentlemen, Those in favor of adopting the motion of Dr. Cain, let it be known by saying "aye." (The motion was carried.)

DR. WALLACE: I am sure I can speak for the Executive Committee and say we are very grateful for this motion and its passage by the House. If I may be granted just a word or two in regard to the Comptrol-

ler and the Attorney General. They are officials of the State and subject to call by an department at any time for legal advice, we do not lose anything by not having them on the Board. I would like to say also just briefly that we feel that the Board of Health is in much better condition than it was a year ago. The Legislature was kind enough to appropriate about one-half million dollars more money this year; they have given us an additional director and so gradually lessening their grip we are more and more coming back on our own and we think the Board of Health will soon be operating, as it did before, for the taxpayer.

We have one bad note, there is a tendency of the Federal funds to be reduced, so we are losing some Federal funds this year.

Dr. Hughes was on the Committee on Public Health and Instruction. He did not write this report:

"We commend this committee for its report but since most of the contents and recommendations have been covered in other reports, no further recommendations are necessary by this reference committee."

Report of Reference Committee on Committee Report on State Hospital for Chronic Alcoholism.

We recommend adoption of Sec. 1, 2 & 3, Page 3, of the report and the consideration of Sections 3 through 8 when funds are available.

They stated when they consulted with the Governor that he indicated there would be no possible chance of money to be appropriated to inaugurate this program. We hope we can look forward to the time when this program can be adopted and put into effect.

The recommendation would require a considerable amount of money but we thought if we went along and recommended the first three of these suggestions, it is like getting your foot in the door, we can make a sale and later on complete the program, we recommend

"1. The creation of a Commission to be known as the South Carolina Commission on Alcoholism, this Commission to include as ex-officio members, the Governor, the State Health Officer, the Superintendent of the State Hospital, and a number of citizens of the State who are known to have a knowledge of and an interest in the subject of alcoholism."

"2. The duties of the Commission shall be to study the problem of alcoholism, including methods and facilities available for care, custody, detention, treatment, employment and rehabilitation of alcoholics."

"3. The commission will appoint from outside its number, and may remove, a full-time Executive Director whose duties will be to supervise the business and financial affairs of the Commission, to cooperate with the Courts, hospitals and clinics, social agencies, educational and research organizations, public health and public authorities, in carrying out the work of the Commission, and to work toward educating the general public on alcoholism."

This Reference Committee thought possibly it would be better to approve these recommendations and get a Commission set up and finally work through that on towards the fruition of the total program and we recommend the adoption of the first *three* recommendations of the Committee on State Hospital for Chronic Alcoholics.

THE CHAIR: As a matter of information, before I put this before the house, that recommendation was from the Special Committee that a Commission be set up. Now, your Reference Committee moves the adoption of the recommendation setting up a Commission. I would like to know, and I am sure the Members of the House would like to know how it is proposed that the Commission be set up, who sets it

up? I can't set it up because the Governor as an ex officio member is on the proposed Commission. What is the method of setting up that commission. Do you want legislation introduced by this body into the General Assembly or what?

DR. WALLACE: To be of any benefit, it would of necessity have to be legislated because it requires the salary and expense of the director. In other words, we are getting into State money and so it would require an Act of the Legislature to set up the Commission.

DR. HUGHES: I think, Dr. Wallace, the recommendation of our Committee was the adoption of Section 1 and 2, not of three (3) since that required an appropriation for the salary of the Director.

DR. WALLACE: I don't see how we could set up a Commission, including the Governor, and son on, without having to have an Act of the Legislature.

THE CHAIR: If you just want a Committee set up to study the subject again, this first committee has made exhaustive study, this committee should go forward at least with some start towards legislative matters to get money for expense and a director.

DR. WALLACE: After we made that recommendation we did include No. 3. I will move, as a member of the House, that the appropriate committee bring this matter to the attention of our attorney to bring it to the attention of the legislature to have appropriate legislation passed.

THE CHAIR: The Reference Committee moves the approval of recommendations 1, 2, and 3 of the Special Committee on the establishment of a hospital for treatment of chronic alcoholism and these recommendations provide for a "Commission" on alcoholism, a Medical Director on alcoholism and an appropriation of funds to support it, and as a supplemental motion of that motion to adopt Dr. Wallace move the Committee on Legislation and Public Relations take steps to bring about in the General Assembly enabling legislation to bring about those things.

Is there a second of that motion made by Dr. Wallace.

(Seconded by Dr. Brabham and others.)

(There was no discussion.)

(A vote was taken and motion passed unanimously.)

THE CHAIR: I will ask the Secretary to give these instructions to the New Committee on Legislation and Public Relations that will be appointed within the next thirty days, if the By-Laws are carried out, and also reverting back to the action that was taken a few moments ago, I will instruct the Secretary to transmit to the New Committee on Public Health the instructions of the House with regard to the changes in the set up in the tenure of office of the Members of the Executive Committee of the State Board of Health.

DR. WALLACE: For some years there have been some bills before the legislature for alcoholics but they required quite a lot of appropriation and there wasn't quite enough public opinion on it.

Regarding the report of Cancer Control Commission "We commend the Cancer Control Commission on their report and work.

"We recommend that every possible means be used to educate the public on the importance of examination and early detection of cancer.

"We urge that every possible means be used to increase the appropriation for enlarging and carrying on the cancer program."

Mr. President, I move the adoption of these two recommendations. (Dr. John Cutchin of Easley seconded the motion of Dr. Wallace; there was no

discussion; the vote was taken and passed and it was so ordered.)

DR. WALLACE: The last report is the report on Committee on Maternal Welfare:

We commend the good work of the Committee on Maternal Welfare. No recommendations were suggested and we offer none.

We have no recommendations to offer but to commend this committee for its good work and which is shown by the continued lowering of the mortality rate in the State. We will compare favorably, I think, with most any state.

Mr. President, I move the adoption of the resolution of commendation for the Committee on Maternal Welfare.

THE CHAIR: The Committee on Maternal Welfare appreciates the commendation. Let me give the MCH Division a little plug for their willingness to help with clinical assistance and also in the matter of paying traveling expenses for members of the committee, where they attend the meetings, and for some stationery and for some postage.

The motion was carried.

DR. WALLACE: I move that my report as a whole be adopted. (This was seconded by Dr. Adcock; there was no discussion; the motion was unanimously carried.)

THE CHAIR: Thank you, Dr. Wallace, we feel grateful for the work done by your reference committee.

THE CHAIR: The chair is very apologetic to Dr. Chas. N. Wyatt, and his committee, I failed to ask for the report of the Reference Committee on Medical Association Work, Dr. Chas. N. Wyatt:

REFERENCE COMMITTEE ON MEDICAL ASSOCIATION WORK

DR. WYATT: The President's report and reports of Chairman of Council, Business Manager and Counsel, The Secretary and Committee on Education were referred to our committee, we went into session at 3:00 o'clock yesterday afternoon and had some few visitors to come to our committee room. We wish to render the following report:

The President's Report is to be commended. Your reference committee wishes to express to the president the sincere appreciation of the Association for his sincere interest, his hard work, his loyalty and time. His visits throughout the state, time consuming as they were, were made unselfishly. He has given much thought to his position as is manifested by the splendid program change that has been tried out during this meeting. We feel that the Association is under lasting gratitude to him for all his untiring efforts. We recommend that his report be adopted and that the plan of this meeting be made permanent.

The Chairman of Council is to be commended for his alertness in attending to the affairs of the association during this past year. We commend his efforts in attempting to clarify the situation which has existed in the State Health Department. We recommend the adoption of his report.

Regarding our Business Manager and Counsel,—we feel that this office is being handled in an efficient manner. We commend the business manager and counsel for his advice and help in all state medical affairs. We recommend the adoption of his report.

We thank the secretary for his report. We commend him in his efforts to keep the members of the association informed on state medical matters and urge a continuation of his efforts. We recommend adoption of his report.

Committee on Education—we urge that the members of this association avail themselves of the educational opportunities offered by the Medical College of South Carolina and the other colleges in adjoining states. We especially urge the attendance of more members at the Post Graduate Seminar of the Founder's Day celebration held annually at the Medical College of South Carolina in order that this splendid program may be continued. We recommend the adoption of this report.

Mr. President, we move the adoption of this report.

(The motion was seconded by Dr. Goldsmith; there was no discussion; the vote was taken and unanimously passed.)

THE CHAIR: The House of Delegates thank you and your Committee, Dr. Wyatt for studying these reports of our officers and finding things in good order.

THE CHAIR: We will now consider the selection of a place for our next meeting.

DR. N. B. HEYWARD, of Columbia gave a warm invitation for the next annual session to be held in Columbia.

DR. CAIN moved that the next meeting be held at Myrtle Beach.

THE CHAIR: We have received an invitation to meet in Columbia and have received a motion to return and meet at Myrtle Beach.

(The vote was taken and 22 were for returning to Myrtle Beach and 23 voted against.)

DR. HEYWARD: I move we have the meeting next year in Columbia.

(The motion was seconded by Dr. Weston Cook; the vote was taken and there were 37 in favor of going to Columbia, S. C., and 15 opposed.

THE CHAIR: Columbia has been selected for the meeting place of the Association for next year.

DR. JULIAN PRICE: In view of the fact that we have established a Grievance Committee and that the members of the Committee will be elected shortly, I move that we request the Chairman of Council to meet with the Grievance Committee as soon as possible after election and preside until after the officers are elected.

THE CHAIR: It has been moved that the Grievance Committee, which will be elected under election of officers, be requested to meet with the Chairman of Council for organization immediately after the adjournment, is there a second?

(The motion was seconded by Dr. Goldsmith and others; there was no discussion, it was voted on and carried unanimously, and it was so ordered.)

THE CHAIR: Under the amendment to the By-Laws, as offered this morning, the House will elect members of the Grievance Committee. The nominations for those places have already been made in anticipation of this action of the House. The nominations have been made by the Council, the actual nominations, within the council, being made by the respective councilor from the several districts, and I have had placed on this blackboard the nominations that the Chairman of Council will announce early this afternoon. It might be of interest to you to study these and give some thought as to which you prefer. There are 18 nominees, two from each district, and this might be an opportunity for you to give some thought as to which of the nominees will suit your own pleasure best.

THE CHAIR: I want to appoint the following tellers:

Dr. Robert Wilson, Jr., Chairman
Dr. T. G. Goldsmith
Dr. Lesesne Smith

I will ask the Executive Secretary to act as Clerk to the tellers.

The Chair will ask for nominations for President-Elect.

DR. WM. WESTON, JR.: Fellow delegates, members. It gives me pleasure to propose the name of a man to lead our organization who has the unanimous support of his county and district medical societies. I have known this man for years, he has sterling character, and is an upright and honest Christian gentleman. I have watched him grow in stature. He is well fitted to keep the cogs of the wheel greased and oiled so that the medical association will continue to function in a smooth manner. He will fight the socialism of medicine. He is married, has one child, a boy, and is an Episcopalian. He has served on the Council for two or more consecutive periods. I think you will find him well qualified and equipped to lead capably our association. He possesses the intestinal fortitude of a fearless leader. I refer to Dr. C. R. F. Baker, of Sumter.

(The nomination was seconded by Dr. Wesley J. Snyder of Sumter, Wyman King, Dick Hanckel and others; Motion was made that the nominations be closed and that the Secretary be instructed to cast a unanimous vote of the House of Delegates for Dr. Baker; this was seconded by Robert Wilson; a vote was taken, it was unanimous; and the secretary was so instructed.)

DR. N. B. HEYWARD: The Secretary takes great pleasure in casting the unanimous ballot for Dr. Baker, as President-Elect.

THE CHAIR: Since Dr. Baker is not in the house I will ask Dr. Wyman King and C. M. Wyatt to find Dr. Baker and bring him to the rostrum, please.

The next in order is nomination and election of a man to serve as Vice-President.

DR. BARRON: I would like to nominate Dr. George D. Johnson, of Spartanburg.

(This nomination was seconded by Dr. D. L. Smith, of Spartanburg, who moved that the nominations be closed; this motion was seconded by Dr. Adcock and motion made that the secretary cast a unanimous ballot for Dr. George D. Johnson. A vote was taken and the motion carried unanimously and it was so ordered that the secretary cast a unanimous ballot for Dr. Johnson for Vice-President.)

(Dr. C. R. F. Baker comes into the assembly hall and the House of Delegates rises as he comes to the rostrum escorted by Drs. C. N. Wyatt and Wyman King.)

THE CHAIR: Gentlemen of the House, I want to present to you the President-Elect of the South Carolina Medical Association, Dr. Baker.

DR. C. R. F. BAKER: Mr. President, Members of the House of Delegates. I am indeed honored by the confidence that you have expressed in me today. I wish that I could get up here and say this came as a complete surprise to me, but that wouldn't be the truth because I know that a lot of my friends have been working hard for several months to get me elected, in fact one of the nicest things about this thing has been to learn how many good friends I had all over the state. During my nine years as a member of Council I tried to carry out my duties as thoroughly and conscientiously as I could. As your President I will try to do the same, thank you.

THE CHAIR: The next in the order of business will be the election of a SECRETARY.

DR. N. B. HEYWARD: Gentlemen of the House of Delegates. Two years ago you elected me to the office of Secretary. I appreciate it very much. According to

the Constitution it is an honorary position, I have thoroughly enjoyed it two years, everybody has been most kind and cooperative and I feel it is time for someone else to take this honor, it must be scattered around, I don't believe in any secretary staying in too long, not an honorary secretary. I appreciate it very much and I take the occasion to nominate Dr. Robert Wilson, Jr., whom I only beat by one vote, to succeed me as *secretary*.

(This nomination was seconded by Dr. Wyatt: There were no further nominations; motion was made that the nominations be closed, this was seconded and unanimously carried, when voted on.)

THE CHAIR: The only nomination before the House is that of Dr. Robert Wilson, Jr., those in favor of his election let it be known by saying "aye," (there was no vote against, so the vote was unanimous.) Dr. Wilson, Jr., is our *Secretary*.

Under the amendment to the By-Laws that was passed this morning, the *Treasurer* is nominated by the Council. I will ask the Chairman of Council if he has a nomination to place before the House at this time, Dr. Mayer.

DR. O. B. MAYER: Council nominates Dr. Howard Stokes to succeed himself.

THE CHAIR: Gentlemen, I hope you realize that you don't have to elect the nominee of Council, you can fail to elect him. It is not your privilege to nominate someone else, but you can instruct somebody else to bring forth another nominee.

Those in favor of *Dr. Howard Stokes, as Treasurer*, of the Medical Association, let it be known by saying "aye." Opposed "no." *Dr. Stokes* seems to be unanimously elected.

THE CHAIR: The Secretary has informed me that Councilors from the 2nd, 5th and 8th Districts have terminated their term of office, these are 2nd Dist.—Dr. O. B. Mayer, 5th Dist., Dr. C. S. McCants; and 8th Dist., Dr. J. H. Gressette.

The terms of all of these gentlemen have expired and it is our duty to elect successors to serve until 1952, the Chair will entertain nominations.

DR. WYMAN KING: I nominate Dr. Mayer to succeed himself.

(This nomination was seconded by Dr. Weston; motion was made by Dr. Cheatham that the nominations be closed, this was seconded by Dr. William Weston; it was moved that a unanimous ballot be cast for Dr. Mayer to succeed himself as Councilor from the 2nd District, it was so voted and the Secretary was instructed to cast the ballot.)

DR. FLOYD: I would like to nominate Dr. C. S. McCants of Winnsboro to succeed himself as councilor of the 5th District.

DR. ED. BARBER: I would like to nominate Dr. R. L. Crawford, of Lancaster, as councilor of the 5th District.

THE CHAIR: Any further nominations? (There were none.)

This will call for a ballot vote, we will prepare the ballot.

(Dr. George D. Johnson, was asked to come to the rostrum.)

THE CHAIR: In your absence you have been elected Vice-President of the S. C. Medical Association and it gives me great pleasure to present you to the House.

DR. GEO. D. JOHNSON: I appreciate very deeply this signal honor which you gentlemen have bestowed on me and I will try to handle the Vice in the best possible manner.

THE CHAIR: I would like nominations for councilor from the 8th District, Dr. Gressette's term of office is expiring.

DR. BROWNING: I nominate Dr. J. H. Gressette to succeed himself as councilor of the 8th District.

(This nomination was seconded by Joe Cain and many members; there were no further nominations; a vote was taken and Dr. Gressette was unanimously elected.)

THE CHAIR: The terms of office of Dr. N. B. Heyward and Dr. E. M. Dibble, whose terms on the Board of Medical Examiners expire, Dr. Heyward from the State at Large, and Dr. Dibble from the 7th District. In addition to that Dr. C. H. Blake, who because of ill health has sent in his resignation, is also to be replaced, whom will you nominate for member of the Board of Medical Examiners from the State at Large?

DR. GEO. D. JOHNSON: I nominate Dr. N. B. Heyward to succeed himself.

(This nomination was seconded by Dr. Durham; Motion by Dr. Evatt that nominations be closed: This was seconded and motion made that a unanimous ballot be cast for the re-election of Dr. N. B. Heyward; a vote was taken and it was unanimous.)

THE CHAIR: It gives the Chair pleasure to cast the unanimous ballot and extend congratulations to one who has served on this Board so long with such significant capability and satisfaction.

Now, the 7th District, to replace Dr. E. M. Dibble.

DR. JOE CAIN: That is the 6th District, and I would like to nominate Dr. E. M. Dibble to succeed himself. (This was seconded by Dr. Johnson, and motion was made that nominations be closed, this was seconded by Dr. Weston; the vote was taken and Dr. E. M. Dibble, of Marion, (6th District) was unanimously elected to succeed himself on the Board of Medical Examiners.)

THE CHAIR: Now, a successor to Dr. C. H. Blake, who has also served a long time and who has resigned because of ill health, the chair will entertain nominations for his successor.

DR. N. B. HEYWARD: I contacted Dr. Blake when he resigned, he tried to resign from the Board earlier, we made him hold on until he was sure he could not continue, he finally wrote me a letter the other day that he was physically unable to do the work. We asked him to survey the four counties, the territory he represents and suggest someone; he has suggested Dr. W. P. Turner, Jr., who is the son of old Dr. Turner. He is a comparatively young man, a graduate of the Medical School in Charleston, and a very high class man and Dr. Blake nominates Dr. Turner.

(This nomination was seconded by Dr. Sease.)

THE CHAIR: Dr. Blake is not a member of the house, he has suggested that Dr. Turner be nominated.

DR. ADCOCK: I nominate Dr. W. P. Turner, Jr., to succeed Dr. C. H. Blake. (This nomination was seconded by Dr. Adcock; there were no further nominations; A vote was taken and Dr. Turner was unanimously elected.)

THE CHAIR: The term of Dr. J. D. Parker, as Member of Board for Examination of Nurses is at an end and he refuses renomination. The Chair will entertain nominations for a successor.

DR. COOK: I nominate Dr. Wyman King of Batesburg.

(This nomination was seconded; motion was made and seconded that the nominations be closed; and this motion was voted on and passed and a vote was taken for those in favor of Dr. King and Dr. Wyman

King was elected a Member of the Board for Examination of Nurses. The vote was unanimous.)

THE CHAIR: The tellers have just given me the result on the ballot of Councilor from the 5th District.

Dr. R. L. Crawford received 36 votes.

Dr. C. S. McCants received 35 votes and the Chair declared Dr. Crawford elected to that place.

THE CHAIR: Now, the election of members to the newly created Grievance Committee. According to the By-Laws nominations were made by Council, two members from each District, each of whom must come from a separate county. I will ask Chairman of Council to state the nominations for the Grievance Committee, Dr. Mayer.

DR. MAYER: There are 18 names to be presented and 9 to be elected. The following list gives the 18 nominations of Council:

District	Name	Place	To Serve To
1st	J. A. Seigling	Charleston	1954
	W. A. Black	Beaufort	
2nd	Weston Cook	Columbia	1955
	W. W. King	Batesburg	
3rd	R. B. Scurry	Greenwood	1956
	R. E. Livingston	Newberry	
4th	J. R. Young	Anderson	1954
	T. G. Goldsmith	Greenville	
5th	Roderick MacDonald	Rock Hill	1955
	J. N. Gaston, Jr.	Chester	
6th	Archie Sasser	Conway	1956
	Walter Mead	Florence	
7th	N. O. Eaddy	Sumter	1954
	Keith Sanders	Kingstree	
8th	W. R. Tuten, Jr.	Fairfax	1955
	O. Z. Culler	Orangeburg	
9th	Wm. Hendrix	Spartanburg	1956
	Joe Guess	Union	

DR. MAYER: Under the terms of the By-Laws, those elected today from the various districts will serve to the date written by that District. The reason is that these terms of office are run concurrently with the councilor from the district in which they come.

(The names were read by the teller from the black-board slowly enough for the members to write their choice on their ballot.) (The tellers collected the ballots and tabulated them.)

THE CHAIR: The Chair has made another oversight, there is another election to be held, that is the

position of hospital Advisory Board to the State Board of Health. There are two to be elected, the terms of Dr. Roderick MacDonald and Dr. M. R. Mobley have expired. The Chair will entertain nominations to fill these vacancies.

DR. LESESNE SMITH: Mr. Chairman and delegates, we have a man from Spartanburg County who has operated a hospital successfully and well for the past twenty years, no state aid or county aid, and he runs a good hospital and has done it well. If put on this committee it will not only help him but it will help the Hospital Advisory Committee, I nominate Dr. Belton Workman of Woodruff.

THE CHAIR: Are there any other nominations?

(Dr. Wallace seconded the nomination of Dr. Workman.)

DR. W. R. MEAD: I would like to nominate Dr. M. R. Mobley to succeed himself. (This nomination was seconded. Motion was made by Dr. Wallace that the nominations be closed and that Dr. Workman and Dr. Mobley be elected by acclamation. This was voted on and was passed unanimously.)

THE CHAIR: I want to express to each one of you my personal appreciation for the courtesies that have been shown the Chair and for your willingness to overlook my numerous oversights and failures. You have been very very kind to me and as I look back at my term of office as President, I can look back to what I looked forward to with dread, namely the conduct of the business of the House of Delegates.

(Recess declared until the tellers are ready to report.)

THE CHAIR: I want to announce the Grievance Committee:

J. A. Seigling, Charleston	-----1st Dist.
Weston Cook, Columbia	-----2nd Dist.
R. B. Scurry, Greenwood	-----3rd Dist.
T. G. Goldsmith, Greenville	-----4th Dist.
Roderick MacDonald, Rock Hill	-----5th Dist.
Archie Sasser, Conway	-----6th Dist.
Keith Sanders, Kingstree	-----7th Dist.
W. R. Tuten, Jr., Fairfax	-----8th Dist.
Joe Guess, Union	-----9th Dist.

This group is to meet with Dr. Mayer, Chairman of Council for organization immediately after adjournment.

If there is no further business the Meeting of the House of Delegates is adjourned.

ADJOURNMENT

The Journal of the South Carolina Medical Association

EDITOR: Julian P. Price-----

Florence, S. C.

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AUGUST, 1952

HOUSE OF DELEGATES

This issue is devoted to the minutes of the recent annual meeting of the House of Delegates. Members of the Association would do well to give more than a cursory glance at these proceedings. Ours is a democratic organization with each elected delegate privileged to express his opinions without danger or gag rule or steam roller tactics.

As one reads these minutes, one is struck with the fairness and tact with which the presiding officer, Dr. J. D. Guess, handled the business. He kept the wheels rolling and at the same time refused to allow anyone to be pushed aside if he wished to speak upon a given resolution. There were few parliamentary tangles and these were handled well.

The recent meeting shows the method in which a business session should be held. If all of our Presidents could preside as well as did Dr. Guess, all would be well. Such, however, has not always been the case, and this is easily understandable. A man may be a natural leader of his colleagues and yet not be one who is gifted in parliamentary procedure.

This brings up the desirability of having a Speaker of the House for our business sessions. A proposal to create such an office was presented at our recent meeting and the final decision will be made during our 1953 session. Members of the Association would do well to discuss the matter fully in the coming months.

FROM OUR PRESIDENT

ORGANIZED MEDICINE'S PLACE IN THE PRESENT SCHEME FOR SOCIALIZATION OF THE UNITED STATES

The present attempt to socialize medicine is a part of the over all picture of a complete overthrow of our present mode of life and government in the United States and the substitution for this method of living, that of a socialistic state. I make this statement and I believe that anyone who gives the problem a careful and thorough examination will be forced to agree with me.

If you will study the writings of Socialistic or Communistic leaders—call them either as you choose—you will note that there has been made a plan to overthrow the government of this United States a great many years ago. You will also note that this plan did not foresee the use of force except in the last stages. It was realized by these brilliant men that such an attack would not be successful. They felt then, and they have endeavored to carry out their thoughts, and their followers have also done likewise, that a campaign to overthrow our government and substitute one of Socialism or Communism could not be successful unless a free medical profession was first destroyed. The

writings of these early leaders definitely contain statements that the destruction of free medicine is the keystone of the formation of a socialistic state. The activities of our medical profession are so closely interwoven into our every day family life and government that it would be impossible to go into a socialistic regime without first destroying medicine as we know it. These early planners realized that the so-called "soap box orators" or the wild-eyed, bearded communists pictured in our comic strips would not be successful in the United States. They knew that they must overthrow our government by a movement, progressing step by step, gradually infiltrating our family life and gradually destroying all obstacles, slowly but surely, by this method. It was thought that the schools would be a principal avenue of approach and that gradually the young people could be taught all types of communistic doctrines—not too rapidly or too radically, but a little at a time—eventually creating a citizenship which would accept all of their doctrines and gradually reject the faiths of their fathers. Our whole public life, including our schools, our churches, our modes of entertainment—such as the theater and the moving picture industry—as well as our newspapers has been subjected to a definite, carefully studied plan of infiltration.

I ask each of you to carefully analyze these statements which I have just made and I believe that you will readily see the effects of this campaign in your own everyday life.

Most of the early changes leading towards socialization of our government are made by those who do not realize what they are doing. Do not be misled. The brains behind the movement know exactly what they are doing and do not for one moment think that these brains are inferior. Certain of their dupes may be lacking in intelligence, but the over all planners for this socialistic regime, both past and present, are brilliant. Following this pattern, there has been a definite effort to undermine men's faith in their women folks, to make marriage less respected, to make the position of women as queen and head of our homes less secure. *All of these gradual changes have been made in the guise of improvement.*

I say to you, be extremely careful in changing any time honored precedent or custom in any of the basic activities of your lives for something new, it may be a step towards socialism. These changes are always sugar coated. There is always an alluring bait cast out in front of us when they expect to have us give up some of our fundamental rights or privileges in order to accept or receive something which apparently is free from an all powerful socialistic movement.

I have no fear of the conquering of the United States by a known enemy who makes a frontal attack

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Comparative Response to Common Methods of Therapy in Distal Colon Stasis*

Number of Hours Residue is Retained							
	24	48	72	96	120	144	168
Control (No Therapy)				○ ○ ○	○ ○ ○ ○ ○ ○ ○ ○ ○ ○	○ ○ ○ ○ ○ ○ ○ ○	○ ○ ○
METAMUCIL	● ● ● ● ● ● ● ● ● ● ● ●	● ● ● ●	● ● ● ●	●	●		
Enemas	●	● ●	●	● ● ● ●	● ● ● ● ● ● ● ●	● ● ● ●	● ● ● ●
Antispasmodics				● ● ● ●	● ● ● ● ● ● ● ● ● ● ● ●	● ● ● ● ● ● ● ●	● ● ● ●
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*Barowsky, H.: A Roentgenographic Evaluation of the Common Measures Employed in the Treatment of Colonic Stasis, Scientific Exhibit, National Gastroenterological Association, Chicago, Sept. 17-22, 1951.

in spite of the inroads of socialism in the past few years, but I do fear the boring from within which is constantly and continually going on and which, if not stopped, will cause the eventual collapse of our great government.

Speaking specifically of our medical problem, I feel confident that all of you are familiar with the fact that in foreign countries where socialization of medicine has been accomplished it has decreased the efficiency of the profession. It has substituted a lifeless, almost automatic type of medicine for a free thinking and free acting profession. Impartial observers have felt that the cost of government medicine has been prohibitively high, that in spite of getting an inferior product these countries are paying proportionately more for what they are getting. You older men distinctly remember the time when the Heidelberg, the Vienna, the Paris and the Edinburgh clinics dominated the world. Their men who are still living and their successors have just as much brains and ability, but the reason why these groups no longer dominate medicine is that their freedom has been taken away. Now everyone realizes that medicine of the world is headed by the medical profession of the United States. America has been the source of practically every worthwhile improvement or perfection in medicine in the past twenty-five years.

Again I want to comment on the strangeness of a group who wish to destroy such an efficient profession and to again reiterate the reason why they feel this profession must be destroyed is that this group will prevent them from accomplishing their true purpose, the ultimate socialization of the entire United States.

To take away a man's privilege to choose his own physician and to take away his privilege of going to the hospital of his choice, of discharging the physician if he feels that he is not adequately doing his work, to move from one hospital to another if he feels that he or his loved ones can be benefited by the change would be a great step towards taking away his incentive to resist socialization of the entire government.

I do not believe that it is necessary for me to go into any great detail as to the reasons why socialization would be extremely detrimental to the practice of medicine—both from the profession standpoint and from the patient's standpoint—with an audience of this type; however, I will briefly review some of the disadvantages.

The paper work would be tremendously increased and would be extremely burdensome. The stereo type of practice would be discouraging and would have a tendency to curb rather than stimulate constructive new thought. Governmental inspectors would be obnoxious and troublesome. Political control would be inevitable and the practice of medicine would be definitely regimented. The cost of this inferior medicine would be greatly higher than at present to the individual. The profession would become unattractive to the best brains of the country due to its loss of prestige and influence. Suffice to say, any of you can add many other definite disadvantages in finitum.

Now, the problem which confronts us is what we can do about this matter. First, we must clean our own house. We must make certain that we do not sponsor or protect those among us who do not represent the highest in the profession. We must see to it that an adequate number of doctors are trained and are available to the public. We members of the profession must see to it that the rural communities are well taken care of. Of course, we do not expect to return to the "horse and buggy days" of the practice of medicine any more than we expect to give up the new discoveries and advantages in medicine. Medicine has changed, but it still must be available to all walks of life in adequate quantities and in unquestionable quality. We must remember that we are under constant

fire, that our every act is being studied by our enemies and for this reason we must be especially careful in all of our public relations. We should encourage good public relations. We should encourage grievance committees who thoroughly and impartially look into grievances between patients and physicians. We are all human. We are bound to make mistakes. We are bound at times to make human errors in our dealings with patients and in a big profession such as we have, we will inevitably have some present who do not adhere to the high principles of the majority. We must force this very small percentage of physicians to conduct their work in such a manner that the vast majority of doctors will not be harmed by isolated instances of selfishness and even worse type of actions on the part of this very small minority. A doctor should also be a citizen. He should take an active interest and a part in politics—both local and national. He should use his influence for good and he should fight the efforts of the socialistic planners in every possible way. As counselor and guide to his patient, he should point out any type of scheme which he recognizes as a part of the picture to overthrow our present form of government. He should conduct his private life in such a manner that he will not cause discredit to the profession. He should be an educational bureau, a maker of goodwill for the medical profession at all times. He should not stoop to petty quarrels or bickering with his fellow practitioner. If he has a difference with his professional colleague, he should see this man in person and thrash it out with him personally, not mouth it over with his patients, because in so doing he has not only hurt himself, but he has hurt the entire profession. The doctor or physician should refrain from charging exorbitant fees and he should cheerfully accept his share of the charity patient burden. Of course, he should make a reasonable inquiry into the patient's status in order that he may not be taken advantage of—either by the patient or by other physicians passing on to him more than his share of this burden. The doctor or physician should actively support volunteer health insurance plans at all times. He should familiarize himself with a group or groups of plans which he can endorse to the patient as being adequate and fair when asked to do so. He should not confine his support to the plans sponsored by the medical profession entirely, but should be open minded to any adequate, honest plan of volunteer health insurance. He should fearlessly condemn the falsely represented type so often sold with the policy practically rendered valueless by the fine type. He should take part in and support all worthwhile activities associated with the profession—such as the present Blood Bank Program—and he should see to it that these programs are run properly and without ulterior motive.

In conclusion, I want to state that the socialism of medicine is only a part of the picture of the socialistic overthrow of our present government. That this movement is extremely intense and that it is present throughout the United States. That its planners are brilliant. That its executors do not always realize what they are doing. That we as physicians should bend our every effort to stop the socialistic movement—both against the profession and against our government. That we should always be conscious of this fact. That we should not be lulled into a false sense of security by minor victories. *If we do this, if we join forces with all of our potential allies, we can succeed. If we do not, we are going to lose.* We have already lost a lot.

Do not forget that the National Parent Teacher's Association has not endorsed a stand against Socialized Medicine, neither has the National Nurse's Association endorsed such a stand.

Lawrence P. Thackston, M. D.

The Journal

of the

South Carolina Medical Association

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Electrocardiographic Changes in Experimental Bacteremia*

JAMES D. NELSON, M. D., F. A. C. P.
Spartanburg, S. C.

During recent years much has been written concerning the changes in electrocardiographic tracings made during the course of many disease states such as typhoid fever, nephritis and scarlet fever, following various types of drug therapy, postural and thermal changes. A majority of the observations made indicate that certain changes take place, most of which are non-specific in nature. Porter and Bloom¹ were able to show that in 46% of cases of typhoid fever, certain changes were noted, primarily affecting the P-R interval and appearance of the T waves. Thomson² was able to show that the height of the T-wave varies in direct ratio with the level of the serum potassium. A review of the recent literature has not shown the changes observed in experimental bacteremia, and an opportunity to make this study has been utilized, with the findings as follows:

Method of study: Fifteen healthy rabbits were selected as controls, and the three standard leads were taken on each animal. Not being familiar with the influence that posture, exact body position, position of the electrodes and other minor details might have on these control rabbits, a second control tracing was made one week after the first. These two series of tracings were compared and found to be identical with the exception of slight variation in heart rate.

Following the control period, each animal was given intravenously .05 cc of viable antigen twice each week for an average of eighteen weeks. The organism used was a nonhemolytic streptococcus. In some instances, when the rabbits appeared too ill, the injections would be omitted until an improvement in temperature was noted. An electrocardiogram was taken at the end of nine weeks, and another at the end of the entire eighteen week period. The temperature and weight of each animal was recorded daily.

RESULTS: Only one of the animals failed to survive the experiment; this animal died at the end of eleven weeks, following the second injection of antigen. Immediately thereafter, there was a continuous elevation of temperature and weight loss until death occurred at the eleventh week.

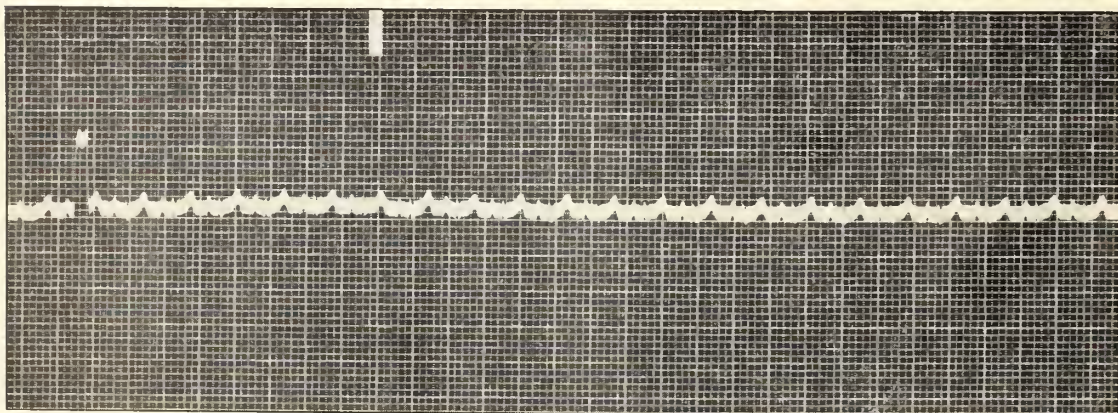
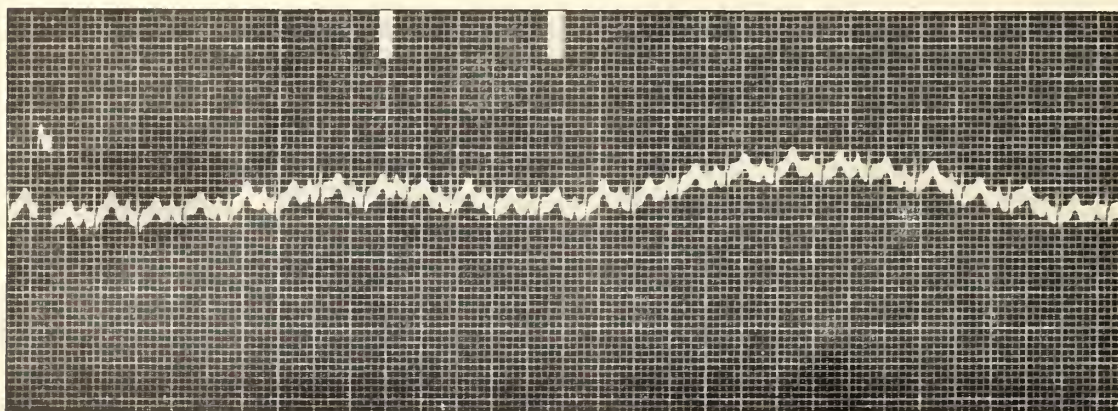
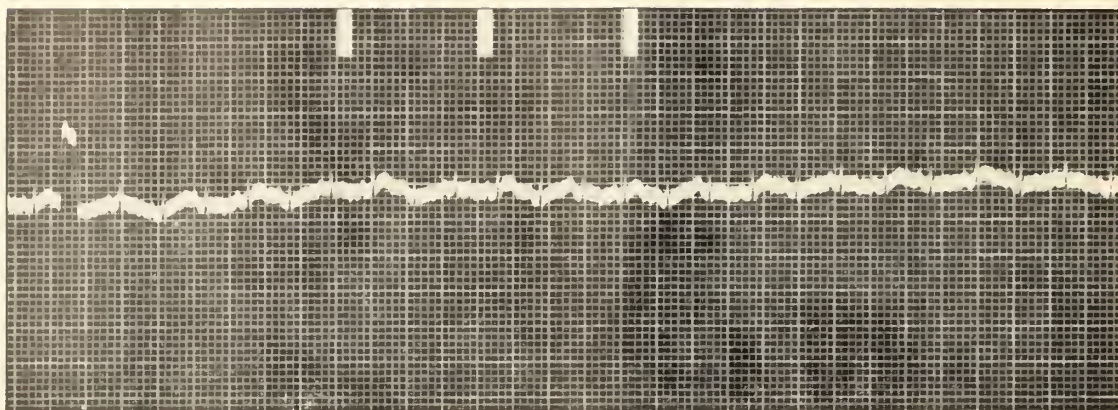
All of the rabbits were made ill by the infection, as evidenced by the temperature changes, and in some instances by the weight loss. Previous experience with these animals has proven that a continuous subnormal temperature is about as significant of ill health as is an elevated temperature. All of the animals except one had an elevated temperature sometime during the course of the period. The average number of days of temperature elevation for each rabbit was 10.6, varying from .4 degrees F. to 1.6 degrees F. Some were elevated for only two to three days, while others were elevated for as long as six weeks continuously.

All but two rabbits had subnormal temperatures at some time during the course of observation. The average number of days of subnormal temperature for each rabbit was 7, varying from .4 to 1.6 degrees subnormal. A few of the animals only had subnormal readings for 4-5 times, and others for as long as six weeks. Sinus rhythm was maintained throughout all the tracings. The changes in pulse rate did not appear significant. The average pulse rate of the control group was 242, while the average pulse rate after the eighteen weeks of infection was 236. This difference is considered to be largely due to the excitement of the animals when being handled for the first time. The changes in electrical axis were not marked as a rule, although in three cases, or 20%, a definite left axis deviation was produced in animals which had normal axis on their control tracings. The average electrical axis of the control group was 62 degrees, and after injection was 38 degrees.

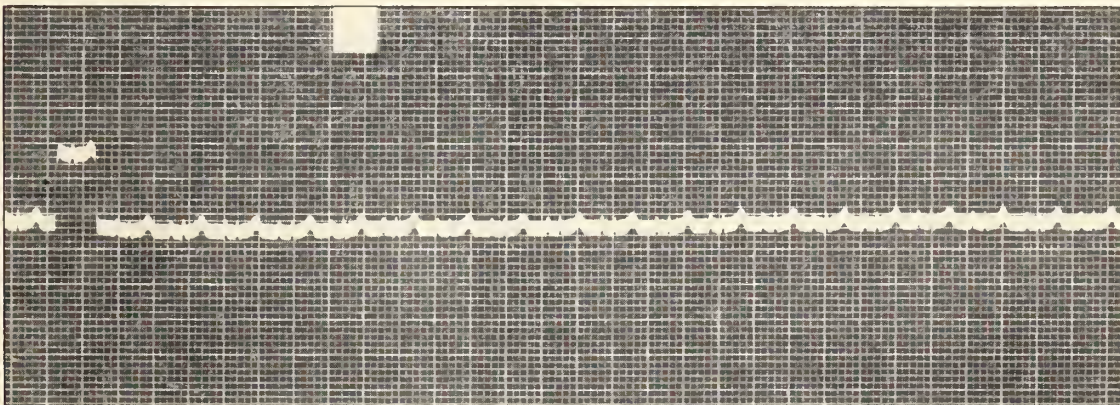
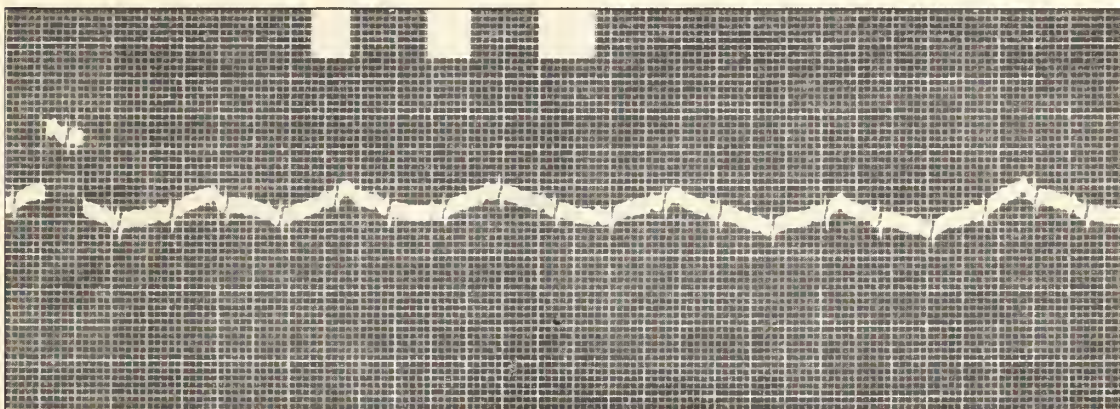
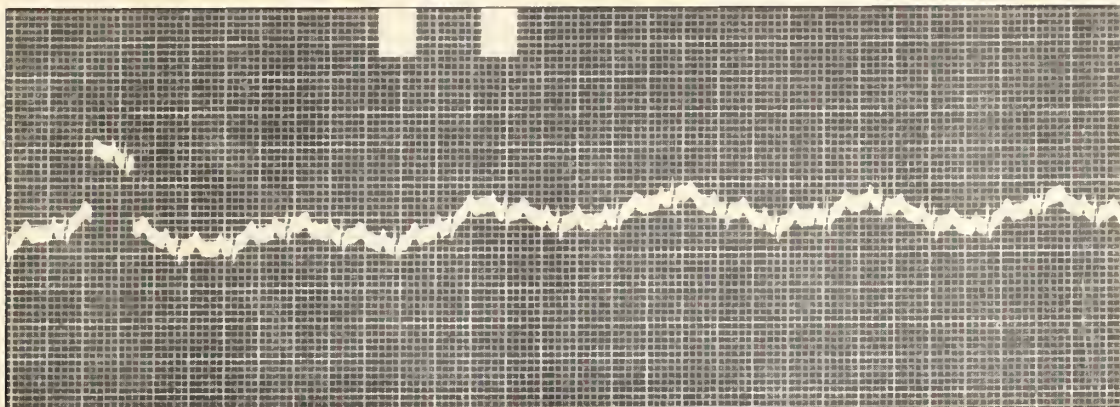
The following table shows the changes in some of the individual deflections:

	Control		After injections	
	Lead 1	Lead 3	Lead 1	Lead 3
Average height of P wave	.46 mm	.6 mm	.52 mm	.3 mm
Average duration of P-R interval	.06 sec.		.06 sec.	
Average duration of QRS complex	.02 sec.		.02 sec.	
Average height of T waves	1.24 mm	.85 mm	1.18 mm	.04 mm

*From The Medical Research Foundation, Frankford, Pa. Through the courtesy of Dr. Martin E. Rehfuess, Director.



CONTROL TRACING



Tracings after injections. Note the change of axis and appearance of T waves.

Comment: In an experiment of this kind, it is difficult to be entirely accurate with measurements when the deflections are so small. However, reasonable accuracy can be maintained to a degree that will enable one to group the electrical changes noted. Of the changes observed, the most interesting are the changes noted in the appearance of the T waves, and the tendency to left axis deviation.

Summary: 1. Fifteen rabbits were selected, and control weight and temperature records were obtained and the three standard leads recorded.

2. Each rabbit was given .05 cc of viable antigen by vein twice each week for a period of eighteen weeks. A broth culture of non-hemolytic

streptococci was used. During this time, a record of temperature and weight was recorded each day, and at the end of eighteen weeks, a final tracing was made on each animal.

3. There is evidence to assume that each animal was made ill by these injections.

4. The tracings taken at the end of the eighteen week period showed definite changes, particularly in the appearance of the T waves and in the tendency to left axis deviation.

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Is The Medical Profession In The Process Of Being Regimented?*

J. HEYWARD GIBBS, M. D.
Columbia, S. C.

Saneho Panza tells us that "true bravery lies somewhere between being a coward and being foolhardy." In acceding to the request that I address this meeting on the subject of current trends toward regimentation of the medical profession, I think that I have shown that I am not a coward; the manner of my dealing with it must determine whether I am truly brave or simply foolhardy.

Regimentation means to organize into groups for central control so that strict order and uniformity can be applied to the group. This ordering of a group, such as the medical profession, can be brought about from within or from without. We shall see that factors are working from both directions as regards our profession.

One does not have to be foolhardy to declare that strenuous efforts are being made from without to control the medical profession. It may be that a certain amount of camouflage and pretense were used, in the beginning, to obscure the full intention of our Federal Government in their plan for the socialization of medicine. These elements of subterfuge have now in large part been dispelled. The fight is in the open, the medical profession has been alerted to the attacks of government upon it, it has organized its forces for the rebuttal of propaganda, and it has partially filled its coffers so that it might fight fire with fire. It should be an interesting fight—you may be sure that it is going to be a long one and a warm one.

The medical profession may or may not be the proper tribunal for deciding as to the advantages or disadvantages to come from governmental control of medicine. Admittedly the profession's welfare, individually and collectively, is so intimately concerned

in the matter as to possibly prevent it from making an unbiased analysis of the subject. On the other hand, it should be possessed of special knowledge that should make its opinions valuable in any *fair* consideration of the problem. The difficulty here is that the medical profession is not yet regimented, in so far as thought is concerned, and we find in its ranks individuals of all complexions of thought. The rank and file of doctors, as represented by The American Medical Association, look upon the governmental program as unsound and undesirable, while we have seen the names of some four hundred medical men, almost all of them occupying prominent positions in academic fields, signed to a statement advocating governmental control of medicine. Some few years ago I saw a meeting of the Johns Hopkins Medical Alumni deteriorate into a verbal riot, in an effort to consider this subject, with such kindly gentlemen as Harvey Stone leading one faction and Hugh Morgan leading the other. Certainly, if I were a layman, and had to form my opinions on the basis of such a debate, I should fall back on the old saw and ask, "who shall decide when doctors disagree."

As I see it, the approach of our Federal Government to the socialization of medicine has *some* elements of reason in it, more plausibility in it, and an *immense* amount of error in it.

What we speak of as reason is a manner of thought that follows recognized paths of logic, where established premises lead to conclusions or where the accumulation of specifics permits of generalizations. For example, we might set up a syllogism somewhat as follows:

In order that democracy, a government of

*Presented at Annual Meeting, May 15, 1952, Myrtle Beach.

the people by the people, shall have a chance of functioning properly it is necessary that the citizenship shall be intelligent and healthy.

Education is the one means that we know of for improving intelligence, and medical care, preventive and curative, is the best means that we know for the maintenance of health. These opportunities for improving intelligence and health should be offered to all of our people, and some agent, sufficiently powerful and wealthy, should insure that these opportunities be available to everyone. The government is the one agent endowed with such power and wealth.

Therefore, it is the duty of the government to furnish education and medical care to its citizens.

With no more logic than this, the individual states have taken over public education—and the Federal Government is busily engaged in horning in on the program. Public education is one of America's early adventures into socialism. Medical care is slated to follow in the same path.

This type of so-called logic comes out of the minds of those that James Forrestal has spoken of as "intellectual muddlers." The premises need to be tested before the conclusions can be accepted. The elements of plausibility are, however, strong, and these elements have popular appeal in them. The public is not much interested in a testing of the premises—they find the conclusions much to their liking—and they care little about the validity of an argument that promises them something for nothing.

Efforts on the part of the Federal Government to socialize medicine have, for the time being, reached a high-water mark and begun to recede. The chief factor in this is a realization on the part of people in general that the socialization of medicine is simply a part of a larger program for the change of our government from democracy to socialism. Changes in this direction have become so apparent, so much that was being done under cover has been brought to light, that the American people now have an opportunity, though it may be a belated one, to beat back the forces leading to statism, a form of government in which they surrender their freedom for security, and find later that they have surrendered both security and freedom. The fight against the socialization of medicine is simply a fight against socialism in general.

It is generally recognized that an excessive national debt is the most effective means for introducing tyranny into government. Such a debt is a lien on private property, in this day of income taxes it is also a charge against the earning capacity of all citizens, and it becomes a means whereby public and private fiscal policies are subject to governmental dictation. The confessed national debt of this country is now more than two hundred and sixty billion dollars, it is distributed among our people, our banks are choked

with government securities, and our subsidiary units of government are heavy investors in this Federal debt. The fiscal structure of this country is today like a house of cards—if one goes down they all go down together. This national debt has reached such proportions that inflation is necessary to service it. We have seen our dollar deliberately debased by act of Congress during the Roosevelt administration to fifty-two per cent of its former value, and we have seen its value continue to fall under the governmental extravagance of the Truman administration until it is now worth no more than one-fourth of what it was some forty-five years ago. We see our government now dependent upon inflation for its actual existence, and we see it deluding our people into believing that it is fighting inflation with all of the means that it possesses. There is only one means for checking inflation, and that is reduction in the national debt. We have seen no move in this direction in, lo, these twenty years!

All of this is mentioned to let you know that unless the trend of your national government toward socialism is checked, there can be no check of the ultimate socialization of the medical profession. It will be regimented along with your society in general.

The medical profession has not been very amenable to regimentation in the past. Of course, it groped its way through the authoritarian night of the Dark Ages along with the rest of mankind. It is interesting to recall that even Andreas Vesalius came very close to abandoning his studies in anatomy when he realized that some of his findings were contrary to the teachings of Galen. Instead, he helped to kindle a light, that was added to by many others in our profession, which has emancipated the mind of man from the suppressive influences of authoritarianism in so-called philosophy, so-called religion and so-called science. When one reads the lives of the leading doctors through the ages, Hippocrates, Galen, Vesalius, Paracelsus, Jerome Cardan, Ambrose Paré, William Harvey, John Hunter, Louis Pasteur, and William Osler, to mention only a few outstanding examples, one realizes that they were not the kind of men to be regimented. No influence, within or without the profession, could have held these spirits in narrow compass. It is likely that men of this type will always stand out as leaders in our profession. They are the few from whom the many profit. Medicine has in it that which encourages individualism; it has in it elements that cannot thrive in an atmosphere of restriction and suppression. Freedom of thought and action are essential to its progress, and I do not believe that any effort, governmental or otherwise, can ever succeed in foisting upon it the withering influence of regimentation.

In our life-time many influences have been brought to bear tending to standardize the practice of medicine. The most important of these is the solid development in the fields of natural science, notably in chemistry, physics and biology, that has led to a genuine understanding of the causes of disease, a clear conception of the natural history of many dis-

cases, the physical and chemical reaction in the body in response to disease, and the biological adjustments by which the body resists disease and repairs injury. The speculative tendencies of fifty years ago have given place to accurate information which is available to the student, and which, in effect, must standardize his approach to the problems of clinical medicine. Thus, science, itself, has to some extent regimented us—and who would have it otherwise. Conformity is now in large part an expression of knowledge; too much individualism is apt to be an expression of ignorance.

Likewise, in our life-time, the standardization of medical education has done much toward making doctors alike rather than different. I can remember doctors whose medical education was acquired in two sessions of six months each, I can remember others who had learned the foundation of their art in the offices of older practitioners, and I can remember the chaotic state of medical education that prevailed in the early part of this century when the unsupervised, uncontrolled, and commercially operated medical colleges held sway. Naturally, there was much of individualism in the products of this type of medical education. Today, our medical schools are all much alike. Their instruction is based on standardized curricula, the scientific background is available to them all, and their graduates are more nearly alike in the basic concepts of medical science than they have ever been in times gone by. Such intangibles as idealism, intellectual curiosity, a discrimination between essentials and non-essentials, and a wholesome desire to test things that are presented to us as knowledge, still vary among our medical schools. They reflect the human qualities of those who teach, and their influence can often be detected in those who have been taught. But this narrowing of differences among medical men must be looked upon as a beneficent accomplishment. If this be regimentation, let's have more of it.

This trend toward standardization in our medical profession, based upon scientific knowledge and clinical experience, is further carried on through our medical associations and our extensive medical literature in all fields of medicine. The good doctor today is the informed doctor; the bad one is the ignorant doctor, who has, for one reason or another, lost the incentive of the student. Dr. Osler remarked that "it is astonishing with how little reading a doctor can practice medicine, but it is not astonishing how badly he may do it." Again, this type of regimentation has worked to the advantage of the medical profession. In fact, it is nothing more than an expression of the inherent desire in all professions for self-improvement. But, even here, the erstwhile student, learning under the direction of his teachers, must become a student in his own right, interpreting his own experience as well as interpreting the experience of others, and, to attain the highest reaches of medicine, he must become an individual thinker and doer. In other words, he must reach the point, described by Marcus Aurelius, where

"a man must stand erect, not be kept erect by others."

Even the field of therapy has become somewhat standardized. On the good side is the scientific pharmacology which tests the manner of working of drugs and biologicals in their application to human disease and disorder, and which gives precise information to guide us in our clinical use of these remedies. On the bad side, is the influence of the drug manufacturers through their literature, that clutters up our mail, and their detail men that visit our offices, bribe us with samples, and steal away our brains with dogmatic statements concerning the efficacy of this preparation or that. Not long ago my secretary said to me, "there was a very nice detail man here this morning who insisted upon seeing you. When I told him that you did not see detail men, he asked me, how, then, you succeeded in keeping up with modern medicine. I told him that I did not know but that he might wait and ask you." I wondered what explanation I might have given him. If this be regimentation, our medical journals are engaged in fostering it. The scientific sections of these journals are sandwiched between pages of advertisements of proprietary remedies, many of them with lurid displays and extravagant claims. The first number of one of our leading journals of internal medicine, appearing some five and a half years ago, contained twenty-five pages of such advertisements. The February, 1952 number devoted fifty pages to such purpose. It impresses me as somewhat incongruous to find scientific articles associated so intimately with the claims of drug vendors.

The drug manufacturers of this country have become so wealthy through the exploitation of their products, glaring examples of which are the vitamins and anti-histamin preparations, leading to their abuse rather than use by the medical profession and the public generally, that they are virtually able to subsidize the clinical investigation of their untried remedies by our leading clinics and medical schools. This has led to premature publication of such studies, the advancement of claims that are not supported by the passage of time, and to criticism of the profession for lending itself to such procedures. This custom needs full re-evaluation.

Though these influences toward regimentation of the medical profession may be very real, and on the whole desirable, we need not become apprehensive that doctors are destined to become so much alike as to be hastily mistaken one for the other. No system of medical education has been found whereby wisdom can be conferred along with the M. D. degree, it has not yet been shown that judgment is acquired with knowledge, and there is grave question as to whether education increases intelligence. We certainly have the best informed medical profession that the world has ever known. There is less certainty that our medical men have correspondingly increased in wisdom, judgment and intelligence. As long as disparities exist in these fields, we need have no fear of true regimentation in the medical profession.

Pentothal and Curare in Anesthesia*

CHARLES H. POOLE, M. D.
Spartanburg, S. C.

During the last two decades, two very important agents have been added to the armamentarium of the anesthesiologist. Lundy and Tovell introduced pentothal sodium in 1934 and Griffith introduced curare (Intocostrin Squibb) in 1942. Since their introduction, these two drugs have enjoyed great popularity both in this country and abroad.

Pentothal sodium is a water soluble, ultra short acting thiobarbiturate. The usual method of administration is by the intravenous route and is given in a number of concentrations, varying from the usual two percent down to one tenth of one percent. Induction is rapid and pleasant. These two features alone are responsible, I think, for its great popularity among the laymen and likewise the profession. These two features have in fact caused many of its shortcomings to be overlooked. Is its present important position in the field of anesthesiology justified? This question can be answered in two ways: as a total anesthetic, no; as an important supplementing agent, yes.

If pentothal sodium is to continue to be the valuable agent that it is, we must not use it as a total anesthetic. Large doses, whether administered over short or long periods are potentially hazardous even though the patient appears to be in good condition. After the administration of a large dose of the drug, patients react as they do to long acting barbiturates. The problem is no longer one of barbiturate hypnosis or anesthesia, but one of sublethal barbiturate poisoning, with the inevitable depression of respiration, circulation and the nervous mechanisms which control them.

Two of the drugs shortcomings become quite evident when it is used as a total anesthetic. The first is its weak analgesic property. Those of you who have administered much pentothal sodium discovered soon that it required large doses to completely depress painful stimuli arising from the skin and other tissues richly supplied with pain receptors. The second is its inability to relax skeletal muscle. In an attempt on the part of the anesthetist to overcome these two deficiencies in the drug, large doses had to be given with often disastrous results.

Barbiturates, when employed in anesthetic doses, cause a diminution in the depth of respiration, according to Adriani;¹ and a diminution in the rate and depth of respiration, according to Goodman and Gillman.² Beecher and Moyer³ in investigating in animals the mechanism of respiratory failure under barbiturate anesthesia, have pointed out the dangers involved in anoxia as well as in carbon dioxide accumulation. They state that in animals under pentothal, the respiratory center rapidly loses its sensitivity

to its normal stimulus, carbon dioxide, as anesthesia is deepened, and that under such circumstances, anoxia may so stimulate respiration as to mask serious respiratory depression.

Taking these facts into consideration, it becomes obvious that the inhalation of oxygen with carbon dioxide absorption during pentothal anesthesia is necessary regardless of the length and depth of the anesthetic.

Pentothal sodium, in present day practice, is administered in combination with one or more of the inhalation agents. By using the drug in this manner, a far safer anesthetic can be given. When given in combination with the less potent inhalation agents, nitrous oxide or ethylene, very satisfactory anesthesia is obtained for a large number of surgical procedures. Much less pentothal is required to maintain the same plane of anesthesia when used in combination with nitrous oxide and oxygen. Barton, Wicks and Livingstone⁴ demonstrated this fact in animals and human subjects. They found that about one fourth the amount of pentothal was necessary to maintain the same plane of anesthesia as was needed when pentothal was used alone. They also found that the blood arterial oxygen was increased in these cases. The anesthesia recovery time, which is so important, is greatly decreased. We make it a practice, in our institution, never to use pentothal alone, but use it in combination with an inhalation agent and oxygen regardless of the length or depth of anesthesia necessary.

The fate of pentothal in the body is controversial. Unlike the inhalation agents, which are unaltered in the body, the barbiturate molecule must either be rapidly broken down or conjugated to account for its short action. Earlier, it was believed that the liver was responsible for the detoxification of the short acting barbiturates. Many yet adhere to this theory. Mark et al⁵ found that in man, pentothal breaks down slowly (15% per hour), contrary to previous assumption. They believe that the early recovery is a function of plasma-tissue shift rather than a rapid breakdown. From the most recent investigation, it appears that one is justified to give small doses of pentothal in cases with slight or moderate liver dysfunction.

One of the most valuable properties of pentothal sodium is, it is non explosive. When used in combination with nitrous oxide and oxygen, electro-surgical instruments may be used in direct contact with the agents, without danger of fire or explosion. This adds greatly to its use in modern surgery.

During recent years, there has developed a trend away from the slow, sometimes difficult induction of anesthesia with the various inhalation agents. Because of the compatibility of pentothal with these agents, it

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is becoming more popular to administer the agent to obtain a rapid surgical stage and then maintain the stage with the inhalation agent. This is valuable in the very apprehensive patient, in the strong and robust male and in certain other patients with increased metabolic rates. I do not believe it should be used in this manner routinely nor should it be used in this manner solely to speed up the turnover of patients in a particular operating room. In many cases, varying degrees of anoxia may develop before the maintenance anesthesia is established, necessitating artificial respiration, and in others, this practice actually retards the development of surgical anesthesia by decreasing the intake of the anesthetic gas because of respiratory depression.

From what has been stated, some simple rules might be made concerning the use of pentothal sodium in anesthesia.

1. It should not be used as a total anesthetic agent.
2. Excessive doses should be avoided.
3. It is best used in combination with oxygen or with an inhalation agent and oxygen.
4. It should not be used in cases where the oxygenation of the tissues is impaired as in decreased vital capacity, respiratory obstruction, anemia, shock or in severe cardiac disease.
5. Use with caution in severe liver disease.
6. It is best used in operations of a minor nature and in those of short duration.
7. An excellent choice when electro-surgical instruments are to be used.

An ideal anesthetic agent must include among its advantages the property of muscle relaxation without endangering the life of the patient with an excessively deep plane of anesthesia. Few if any of our general anesthetic agents possess this property. In 1942, Griffith introduced curare into the field of anesthesia, not as an anesthetic, but as an agent to be used solely for the production of muscle relaxation.

Anesthesiologists were quick to adopt the use of this new agent. With it, they could obtain the degree of muscle relaxation they desired with light planes while using the more potent anesthetic agents. It also increased the range of usefulness of the less potent agents. This was indeed a great step in the progress of anesthesia.

The drug curare has a long and very interesting history. For centuries, it has been used by certain South American Indians in hunting and fighting. Crude preparations of curare were made by brewing together the leaves, roots and bark of a number of plants in that region. The drug was introduced into the enemy on darts, arrows and spears that had been dipped into this crude concoction. Explorers returning from this region brought with them samples of the drug in containers made of bamboo tubes, clay pots and gourds. The preparations in these various containers were thought to be different, but Gill,⁶ recently

discounted this idea, saying, regardless of the plants from which a given batch of curare had been prepared, the batch was simply placed in the most accessible container.

Gill⁶ collected and made curare in the field from vines identified as *Chondrodendron Tomentosum*. This work represented the first time that the exact source of a form of curare was recorded. This authenticated type of curare was the source of material from which Wintersteiner and Dutcher in 1943 prepared crystalline d-tubocurarine chloride. D-tubocurarine is the active ingredient of Intocostrin which was the first curare preparation used in the field of anesthesiology.

The curare effect is the interruption of nerve impulses at the myoneural junction, so that the muscle will respond neither to injected acetylcholine nor to stimulation of its nerve. The action is essentially peripheral so that a nerve bathed in curare will still conduct impulses. The curare effect, neutralization of the acetylcholine reaction, the fundamental neuromuscular stimulation mechanism, has been shown to be inhibited by prostigmine. Prostigmine is known to inhibit choline esterase which, in turn, destroys acetylcholine and thus to restore the acetylcholine preponderance at the myoneural junction.

For the typical effect of curare to be observed, it is necessary that it be administered by the intravenous, intramuscular or subcutaneous route through which effective concentrations can be reached. The duration of the effect is short. The drug is eliminated by the kidneys probably unchanged, as pointed out by Boehm, who discovered the curarizing properties of urine collected from curarized animals.

The combination of pentothal sodium and curare has a very important place in the field of anesthesiology. By introducing curare into a patient anesthetized with pentothal we find again an agent that will decrease the amount of pentothal necessary for the particular case. As stated before, pentothal, except in very toxic doses, produces little or no muscular relaxation. In addition, curare inhibits many of the reflex activities so commonly experienced with pentothal alone. Although there is no proof, it was thought by Baird and Johnson⁷ to be a definite synergistic relationship between the two drugs.

Pentothal and curare may be administered by two different methods. The drugs may be mixed in the same solution or given in separate syringes. Pentothal in 2½% strength may be mixed with d-tubocurarine without danger of precipitation. This was not the case when using Intocostrin. Due to the wide difference in the pH of the two drugs, a precipitate of acid pentothal was formed. Intocostrin was acid, pH 5.1 and pentothal is alkaline, pH 10.35. A suitable mixture may be made by mixing five cubic centimeters of d-tubocurarine solution with one half gram of pentothal sodium dissolved in fifteen cc of sterile distilled

water. This results in a solution containing five units of d-tubo and twenty milligrams of pentothal sodium per cc.

In cases where pentothal curare was indicated, I preferred using separate syringes for the two drugs, because it was very difficult to tell in many instances, which effect predominated, the curare or the pentothal. Baird, Johnson and Van Bergen⁷ have used the above mixture in many different types of cases with good results. I have found it a poor choice in abdominal surgery because of the severe respiratory depression.

Pentothal-curare solution is administered intravenously in the same manner as pentothal alone. Because small amounts of the agent are injected over long periods of time, it is necessary to prevent blood from clotting in the intravenous needle. This may be accomplished by the injection of the solution thru the tubing of a continuous intravenous drip. The disadvantages of administration of pentothal-curare solution are mainly of a mechanical nature, such as difficult venipunctures, dislodging or plugging of the needle and leaky connections. If it is necessary to change the position of the patient, the danger of dislodging the needle is increased.

Adequate premedication with morphine and atropine or scopolamine should be given to patients who are to receive pentothal curare anesthesia. This prevents excessive muens secretions and helps in the elimination of laryngospasm which has been a common occurrence in pentothal anesthesia.

Some of the advantages of pentothal curare anesthesia combined with nitrous oxide and oxygen might be stated.

1. Cardiac irregularities are uncommon unless anoxia is present. It has a minimal effect upon the cardiac conduction mechanism.

2. Postoperative nausea and vomiting are not common.

3. Induction and recovery are calm.

4. Circulatory depression is insignificant.

5. The outstanding advantage of this type of anesthesia is the elimination of the explosion hazard. I think it is by far the best choice when electro-surgical instruments are to be used.

My experience with this type of anesthesia is not nearly as extensive as that of many who use it almost routinely. In my hands several disadvantages have overshadowed the advantages. Recovery has been slow in many cases necessitating constant observation until consciousness reappeared. Danger of respiratory obstruction and anoxia are great during the prolonged recovery period. During the anesthesia, respiratory depression is often severe necessitating long periods of respiratory assistance. Prolonged periods of apnea with controlled respiration are sometimes detrimental to circulatory dynamics, resulting in poor cardiac filling and a decreased cardiac output.

Because of the properties of pentothal and curare, this type of anesthesia should not be used in patients with a history of asthma or in those with myasthenia gravis. It should be administered by a competent anesthetist who has adequate facilities at hand for providing artificial respiration and a patent airway.

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The Use and Abuse of Barbiturates*

W. G. MOREHOUSE, M. D.
Columbia

I wish to discuss for a few minutes a group of drugs that any physician has to prescribe practically every day—the barbiturates. No doubt, many of my remarks are familiar to all of you, but I think a review of the barbiturate problem is in order, particularly in view of new legislation which went into effect just recently.

Since barbital, under the trade name “veronal,” was first placed on the market in 1903, over 1500 derivatives of barbituric acid have been made—about 100 of these have been thoroughly tested and manufactured for dispensing. Phenobarbital—trade name “luminal”—is the second oldest of these drugs. Both of them are U.S.P. and have proven their value through the years because of their reliability in producing sedation, their quick elimination and their absence of undesirable toxic effects.

For 75 years before barbital was introduced, bromides were the chief sedatives prescribed. Due to the side effects such as gastric distress and slow elimination of the drug, resulting in bromide rash, mental disturbances and neurological complications, the barbital drugs gained rapid favor. In 1912, phenobarbital was first used in the control of grand mal epilepsy and it is still one of the best drugs for this condition, the only disadvantage being the mild apathy when seizures are fully controlled.

Because of low toxicity and absence of side effects, we were lulled into believing that barbiturates were entirely harmless. I distinctly remember being given the impression in medical school that these drugs could be prescribed indefinitely without fear of addiction, and the first few years I practiced, that was the current feeling.

During and since World War II attention has been called to the tremendous increase in the use of barbiturates, and a study of hundreds of cases of habitual users in large doses reveals that these drugs are addicting. Dr. Harris Isbell, Director of the Research Division of the United States Public Health Service Hospital in Lexington, Kentucky, says that barbiturates are definitely addicting from the pharmacologists point of view in that a characteristic illness develops when the drug is abruptly stopped. The psychiatrist says it is addicting because of the deleterious effects on the personality. The social workers and law enforcement officials recognize it as addicting because of disturbances in social relationships and in tendencies to commit criminal acts. Presently I will show a few slides which will demonstrate more forcibly the problem as it stands today.

Dr. Isbell states that “abstinence from barbiturates is, in fact, more dangerous to life than is abstinence

from morphine.” He cautions doctors to take 3 to 4 weeks in getting a barbiturate addict off the drug and the dosage should not be reduced by more than 1½ grains daily.

I want to emphasize that what I have to say refers to the individual who is using four to ten times the amount usually prescribed. Where it is used as prescribed to produce relaxation in such cases as hypertension or in transient emotional upsets, no harmful effects are noted even with long usage. When it is used as an escape mechanism, we can anticipate a problem. We all recognize that certain of our patients are “habituation” or “addiction” prone—by judicious prescribing with suitable warnings when indicated, we can prevent some of these “sensitized” people from becoming habitual users. Many institutions caring for epileptics have found phenobarbital to be consistently effective in the original doses for years. No appreciable tolerance to the drug is developed in the average case; there is no elevation of the toxic dose, and psychological testing reveals no deterioration. In chronic intoxications, however, the electroencephalogram is abnormal—high voltage waves of fast frequency are demonstrated while taking the drug; and if it is abruptly stopped, these high frequency waves appear in bursts and you know that a convulsive seizure is impending. In fact, the encephalogram at this stage is almost identical with that of a person who has grand mal epilepsy.

I want to show a few slides now to indicate the scope of this problem, to mention a few of the contraindications, and a few suggestions as to how we might actively reduce the frequency of the problem case.

You will see that in only 14 years the use of barbiturates has increased four times. Twenty-five per cent of all poisoning cases that come to the general hospital are due to these drugs. They lead all other drugs in the deaths caused and they are second only to carbon monoxide in effective suicidal attempts. The tragic apparent discrepancy in the last two statements is due to the fact that only one-third of these people meant to commit suicide—the other two-thirds were accidental due to overdosage because of the blurred judgment. In the United States deaths have increased 600% in the last 10 years. The figures have been more striking in the large metropolitan areas: Los Angeles reports an increase of seven times in four years while Chicago's death rate has gone up 13 times in eight years. When we stop to realize that so often suicides and accidental deaths of this nature are given the minimum of publicity because of the importance of the person involved, we wonder what the true statistics actually are.

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A few words about the action of barbiturates: of course, they are primarily used as a depressant of the central nervous system—mild sedation to deep coma can be produced. These drugs, short of anesthesia, have no analgesic properties; but an interesting thing is the marked increase in effectiveness of the salicylates when small quantities of barbiturates are added. The reverse is not true; the salicylates do not enhance the sedative effects of the barbiturates. Another point of interest is that phenobarbital alone, short of anesthesia, is the only member of this group that has anti-convulsive properties. The respiratory system is depressed; death is usually due to respiratory failure. The drugs are not toxic to the heart, but in large doses cause vaso-dilatation. In the absence of disease of these organs, the kidneys are not directly affected; the older, long-acting drugs are eliminated through the kidneys, so if there is renal impairment, they should be avoided. Where there is overdosage, you may have oliguria or anuria. Likewise, ordinarily the liver is not affected, but since the short-acting barbiturates are handled by the liver, they must be avoided where there is impairment of function.

Idiosyncrasy to the barbiturates does not occur often—when it does happen it might be quite puzzling and distressing. Natural idiosyncrasy occurs in some people taking small to moderate doses—they complain of a "hangover" feeling after the sedative effects wear off and may even have a good deal of pain. Acquired idiosyncrasy occurs among those who have a tendency to asthma, urticaria and other forms of allergy. If barbiturates are used in painful conditions, do not be surprised if once in a while restlessness is increased or even delirium is encountered. Among elderly people where there is beginning to advanced sclerosis, these drugs may act paradoxically and your patient will remain awake and restless instead of sedated. Caution should be used where there is a high fever, hyperthyroidism, severe anemia or congestive heart failure.

What legislation has been enacted to help us control the use of these drugs? South Carolina, since 1938 has had a Barbiturate Act; even if they didn't appropriate any money for the enforcement of it until 1945. The present laws require that barbiturates are to be sold only on a prescription, and it must specify

if it can be refilled. Barbiturates may be dispensed by a physician, but if more than one dose is left, it has to be in a container with the patient's name and directions on it. A single prescription may not be refilled more than twice, and then not before the prescribed dosage at the proper times have been observed; and if 60 days elapses from the date on the prescription it cannot be refilled.

Since I have presented a problem, it is only fair to offer some possible solutions to the problem. These certainly are not the only solutions—a respectful recognition of the problem by all concerned will be necessary to lower the poisoning and death rates and restore these drugs to their rightful place in the armamentarium of the physician. First of all, a close observance of the existing laws will be necessary. Restricting laws are irksome, especially to a person in the practice of his profession, but if they are reasonable laws, the inducement to conform is much greater. I believe that unless definitely contraindicated, the patient should know he must follow your directions explicitly and the potential dangers of increasing the dosage should be explained. A good scheme is to rotate the barbiturates with other sedatives such as paraldehyde, chloral hydrate and bromides. Whenever at all possible, if the doctor can spare a few extra minutes to listen, he will often find several clues regarding his patient's insomnia and tension which might indicate to him a relatively simple solution of the situation which will be permanent and not temporizing. One approach to the problem has been the suggestion that emetic drugs be added to the sedatives, so that if an overdose is taken it will promptly be eliminated. One argument against this is that if sufficiently large doses are taken, the emetic might paralyze the center dealing with regurgitation and poisoning would still ensue. Recent work with zinc sulfate indicates it is apparently more effective in this respect than ipecac, due to the local irritant effect on the gastric mucosa rather than dependence on the central emetic effect.

This paper has been written to present the barbiturate problem as it stands today. It certainly is not an indictment against a very useful group of drugs, but a reminder that care must be used if we are to obtain the results we want.

IN MEMORIAM

Again the Memorial Committee brings you the report of those who have died during the past year.

Many of these men served long and faithfully as loyal members of this Association, and devoted their lives to the practice of their art—being true Aesculapians.

No words that we can say will add luster to their names, nor fill the aching hearts of those who loved them.

Truly there is something about a good doctor that sets him apart from other men.

NAME	ADDRESS	DATE OF DEATH
Dr. J. Lee Young	Clinton	May 14, 1951
Dr. William T. Lander	Williamston	May 15, 1951
Dr. William Eugene King	Aynor	May 27, 1951
Dr. Wilson C. Brown	Newberry	July 1, 1951
Dr. S. B. Fishburne	Columbia	July 8, 1951
Dr. Ralph E. Brown	Barnwell	July 17, 1951
Dr. Archie B. Hooton	Olar	September 1, 1951
Dr. Lonnie M. McMillan	Mullins	September 2, 1951
Dr. Hugh E. Wyman	Columbia	September 2, 1951
Dr. Mary Baker Blackburn	Marion	September 3, 1951
Dr. James T. Quattlebaum	Columbia	September 5, 1951
Dr. Peter A. Brunson	Ridge Spring	September 10, 1951
Dr. Otis H. Purvis	Cheraw	September 20, 1951
Dr. Nathan N. Schofield	Marion	September 24, 1951
Dr. Daniel L. Maguire	Charleston	October 6, 1951
Dr. J. Creighton Mitchell	Charleston	October 25, 1951
Dr. William B. Ryan	Ridgeland	November 5, 1951
Dr. Paul L. Nevill	Saluda	November 9, 1951
Dr. Edgar O. Horger, Jr.	Greenville	November 26, 1951
Dr. Augustus T. Neely	Newberry	February 1, 1952
Dr. Robert M. Potts	Fort Mill	February 9, 1952
Dr. Arthur E. Cannon	Converse	February 14, 1952
Dr. Elias E. Cooley	Greenville	February 18, 1952
Dr. Samuel J. Summers, Jr.	Cameron	February 26, 1952
Dr. Thomas N. Dulin	Clover	March 7, 1952
Dr. Hawkins K. Jenkins	State Park	March 16, 1952
Dr. George B. Haselden	Cades	April 1, 1952
Dr. Alexander S. Blanchard	Williston	April 8, 1952
Dr. O. P. Wise	Saluda	April 24, 1952
Dr. John W. Carroll	Russellville	May 4, 1952
Dr. Allen Huggins Johnson	Hemingway	May 14, 1952

(The Annual Report of The Memorial Committee, presented at Annual Session, May 12, 1952)

The Journal of the South Carolina Medical Association

EDITOR: Julian P. Price

Florence, S. C.

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Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

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SEPTEMBER, 1952

FREEDOM OF EXPRESSION OF THOUGHT

Elsewhere in this issue appears an article by Dr. Heyward Gibbs which was presented at the annual session of our state association at Myrtle Beach. That portion of his paper which deals with the activities of drug manufacturers provoked considerable comment and in some instances severe criticism. The ideas which Dr. Gibbs expressed are at variance with those which are held by many practicing physicians and medical societies and the suggestion was made to the Editor that because of this the article should not be printed in this Journal without marked change.

This Journal is the official publication of our state medical association and as such is a medium through which members of the association may present their views. Freedom of expression of thought has been and will continue to be one of the fundamental policies of this publication, even though the sentiments expressed be opposed to those held by the association itself or by a majority of its members. Dr. Gibbs, one of Columbia's leading physicians and one of the state's leading internists, is a member of our association and as such is fully entitled to present his opinions for publication. We have, therefore, printed his article without change.

Freedom of expression of thought is also available to those who disagree with Dr. Gibbs and the Editor wishes to comment upon one particular phase of his criticism of the drug manufacturers, namely that part which deals with advertising in medical journals.

In the latter part of his article, Dr. Gibbs writes, "If this be regimentation, our medical journals are engaged in fostering it. The scientific sections of these journals are sandwiched between pages of proprietary remedies, many of them with lurid displays and extravagant claims. The first number of one of our leading journals of internal medicine, appearing some five and a half years ago, contained twenty five pages of such advertisements. The February, 1952, number devoted fifty pages to such purpose. It impresses me as somewhat incongruous to find scientific

articles associated so intimately with the claims of drug vendors."

Since the above indictment would certainly apply to this Journal we need to examine the facts with care. If the author is correct in his accusation, this Editor would be the first to suggest that we discontinue publication, since it would be impossible for this, and practically every other medical journal, to be printed without the income derived from advertising.

How does the Journal of the S. C. Medical Association secure its drug advertising and what effort is made to see that the advertisements state facts and not fiction? An answer to that question should help to clarify the issue.

Our Journal secures its drug advertising through the State Journal Advertising Bureau of which it, along with 33 other state medical journals, is a member. This Bureau was organized in 1913 by the Board of Trustees of the A.M.A. and its policies and principles have been developed by an advisory committee composed of five state medical journal editors, the General Manager and Secretary of the A.M.A., the Editor of the Journal of the A.M.A., and the Secretary of the A.M.A. Council on Pharmacy and Chemistry. The Director of the Bureau maintains an office in the headquarters of the A.M.A. in Chicago.

The two basic principles which must be met by all advertisers of drugs before their advertising will be accepted by the Bureau are; (1) only those drugs which have been "accepted" by the A.M.A. Council on Pharmacy and Chemistry may be mentioned in the advertisement, and (2) even though a drug has been "accepted," no claims may be made for it in the advertisement which cannot be backed up by scientific evidence. Whenever the Director of the Bureau is uncertain as to matter appearing in an advertisement he immediately appeals to the Secretary of the Council on Pharmacy and Chemistry for information. The A.M.A. Council on Pharmacy and Chemistry is generally recognized as the supreme court in decisions concerning the efficacy of drugs.

The principles which have been adopted by the

State Journal Advertising Bureau also apply to the Journal of the A.M.A. and to all the specialty journals published by the A.M.A.

The editor is convinced that so far as the journals published by the A.M.A., the journals published by most of the other state medical associations, and the Journal of the South Carolina Medical Association are concerned, there is no evidence that "the scientific sections of these journals are sandwiched between pages of proprietary remedies, many of them with lurid displays and extravagant claims." That some of the so-called "throw-away" medical publications are guilty of Dr. Gibbs' accusation, we will not deny. It is no more fair, however, to indict all medical journals for the activities of the few than it is to condemn all physicians as unethical because of the actions of a small minority.

CHLOROMYCETIN

The Federal Security Agency has released the following information with regard to Chloromycetin:

The Food and Drug Administration of the Federal Security Agency announced its decision to permit the continued distribution of the antibiotic drug Chloromycetin under revised labeling that will caution physicians explicitly against its indiscriminate use.

Charles W. Crawford, Commissioner of Food and Drugs, said "The Administration has weighed the value of the drug against its capabilities for causing harm and has decided that it should continue to be available for careful use by the medical profession in those serious and sometimes fatal diseases in which its use is necessary."

The Commissioner said "FDA's decision was similar in principle to one made every day by thousands of doctors throughout the country who weigh the need for a potent drug against the possibility of harm to the patient."

Reports of blood disorders attributed to Chloromycetin led to a Nation-wide survey by the FDA late in June of the case records in hospitals and clinics. The case histories turned up by this survey were referred to the National Research Council for its aid in evaluating the information. FDA's decision today was based on the findings and recommendations of a special committee of the Council's Division of Medical Sciences.

The committee of outstanding authorities on hematology and infectious diseases, was headed by Dr. John Holmes Dingle, Professor of Preventive Medicine at Western Reserve University, Cleveland, Ohio. The committee considered the records of 410 cases of serious blood disorders, of which 177 were definitely known to have been associated with the use of Chloromycetin.

In 61 cases Chloromycetin was the only drug administered. In the remaining 116 cases other drugs had also been given. In both groups fatalities totaled 50 percent, attributable to aplastic anemia and related conditions in which the bone marrow has lost its ability to manufacture both red and white cells of the blood.

A group of 168 cases, including 97 cases of aplastic anemia, was eliminated from consideration by the committee because it was determined that Chloromycetin had not been administered. A remaining group of 65 cases in which Chloromycetin may or may not be involved, continues under investigation.

It is estimated that since the drug came on the market in 1949, it has been administered to something like eight million patients.

AMA NEWS NOTES

OFFERS AID TO DOCTORS DISCHARGED FROM MILITARY

A new program has been set up by the American Medical Association to acquaint physicians newly-discharged from the armed forces with existing opportunities in private practice, industry, hospitals and medical schools throughout the country. Inaugurated by the Council on National Emergency Medical Service, the plan incidentally will also provide replacements for physicians classified priority I under the "Doctor Draft Law" who are now deferred from active military service because of essentiality.

The Council will contact army, navy and air force physicians before they are discharged to find out if they have any post-service plans. If the doctor hasn't made any plans, he may indicate to the Council where he wants to locate and in what field of medicine he is interested. This information will be sent to state medical societies and to state medical advisory committees to the Selective Service System. Correspondence with individual physicians on these lists will be handled by either the state advisory committees or the medical societies.

SURVEY ON RESEARCH PROJECTS

Questionnaires will be sent out this month by the AMA's Committee on Research to determine what medical research projects currently are in progress throughout the country. The survey has a three-fold purpose: To establish an up-to-date file of medical research projects; evaluate the premise that certain fields of medical research are suffering from lack of financial support, and consider the actual contribution of individual scientists in terms of free time and personal expenditure of funds. A random sample of 15,000 physicians from all parts of the United States and selected personnel from medical schools, public health services and pharmaceutical firms will be asked to participate in the survey.

STANDARDS FOR INDIGENT CARE

The Committee on Indigent Care of the AMA's Council on Medical Service has outlined the following criteria for developing indigent medical care plans. The Committee believes that indigent medical care plans should provide all the services which normally are available locally to other citizens, and should make equal services available to all indigent persons—the blind, old age pensioners, dependent children. Also, the Committee feels that such a plan should provide for medical supervision and, wherever possible, offer a free choice of physician for both home and office care. The plan should use existing facilities, avoid duplication and provide for local administration by a single agency of the medical program for all groups concerned.

The Committee believes that medical care for the indigent is a local problem requiring the wholehearted cooperation and participation of local physicians. Such plans should be administered locally regardless of the source of funds.

U. S. MEDICAL SCHOOLS RECEIVE VOLUNTEER GRANTS

The sum of \$671,834 was turned over by the American Medical Education Foundation to the National Fund for Medical Education for distribution to the 79 medical schools in the United States. This represents the amount collected from physicians during the first six months of 1952. This money added to the amount collected from industry by the National Fund for Medical Education was distributed July 31 in the form of grants amounting to \$15,000 to each of the 72 four-year schools and \$7,500 to each of the seven two-year schools.

NEW HEART DISEASE TRANSCRIPTIONS AVAILABLE SEPTEMBER 15

A new series of radio transcriptions entitled "The Heart of America" will be released September 15 by the AMA's Bureau of Health Education. Dramatizing various aspects of the heart and its diseases, the 13 programs in the series are summarized by outstanding cardiologists and related experts. Subjects include: research in heart disease; heart murmur; rheumatism and rheumatic heart disease; the congenital heart disease program; the heart and athletics; coronary disease; overweight and the heart; arterial disease; high blood pressure and the heart; surgery for heart valve and arterial diseases; the heart in relation to stresses and strains; rehabilitation; protecting the good heart from injury, and how to live with a damaged heart. The series was produced in cooperation with the American Heart Association.

HOSPITAL RATING OFFICE OPENS FOR BUSINESS

Director Edwin L. Crosby, M.D., former superintendent of Johns Hopkins Hospital, Baltimore,

opened the new Joint Commission on Accreditation of Hospitals office September 1 at 660 Rush Street, Chicago. The Commission, with representatives from the American Hospital Association, the American College of Surgeons, the American College of Physicians, the Canadian Medical Association and the American Medical Association, will assume responsibility for the hospital standardization program formerly carried out by the American College of Surgeons. The Commission's program will get under way early this fall.

MINUTES OF COUNCIL MEETING
MYRTLE BEACH, S. C. 5-15-52

The first meeting of the new Council was held at 9:30 a.m. in the Assembly Room of the Ocean Forest Hotel, May 15, 1952. The meeting was called to order by the Chairman, Dr. O. B. Mayer. Members present were: Drs. J. P. Cain, Jr., Charles N. Wyatt, J. D. Guess, L. P. Thackston, J. C. Sease, J. H. Cressette, and Robert Wilson, Jr.

Since this was the first meeting of the Council for the year 1952-53, the first order of business was organization. Dr. O. B. Mayer was elected Chairman, to succeed himself, Dr. J. P. Cain, Jr. was elected Vice-Chairman, and Dr. Charles N. Wyatt was elected Clerk.

Dr. Guess brought up the matter of expenses of the President of the Association, and on the basis of his experience during the past year, made the suggestion that provision should be made for payment of the traveling expenses of the President during the year of his term of office and, also, for some amount for his office expense. After discussion it was moved, seconded, and unanimously passed that the President should be paid mileage at the rate of seven cents per mile, and other traveling expenses for all travel on the official business of the Association, as is now provided for the Secretary and the Executive Secretary; also, that he should have an allowance for office expense in connection with work for the Association up to \$50.00 per month if that amount should be necessary.

The following additional budgets were approved:

SECRETARY

Office help	\$1,200.00
Office expense, supplies, tel. and tel.	300.00
Travel	500.00
Total	\$2,000.00

(The foregoing budget for the office of the Secretary is the same as for last year.)

EDITOR

Salary	\$1,200.00
Office Assistant	900.00
Office expense	300.00
Total	\$2,400.00

(Plus cost of publication of the Journal)

**EXECUTIVE SECRETARY
(INCLUDING TREASURER)**

Salary	\$ 7,200.00
Office help	6,000.00
Travel	1,500.00
Office rent	600.00
Office supplies	750.00
Tel. and Tel.	500.00
Heat, lights, water	150.00
Conferences and other	
Public Relations Act.	500.00
Bond Premium	155.00

Total

The Woman's Auxiliary

\$.50 per member (estimated)	\$ 600.00
Historical Commission	\$ 100.00
General Contingent Fund	\$ 1,000.00

On motion of Dr. Wyatt, seconded by Dr. Sease, the Treasurer was directed to transfer \$5,000.00 from the General Fund to the Association's Reserve Account.

Dr. Julian P. Price was re-elected Editor and Mr. M. L. Meadors, Executive Secretary, both unanimously.

The dates for the Annual Meeting in 1953 in Columbia were tentatively fixed for Tuesday, Wednesday and Thursday, May 12, 13, 14, 1953. The selection of these dates was contingent upon the ability to make satisfactory arrangements with the Columbia Hotel, and the Executive Secretary was directed to contact the Hotel Manager and ascertain if there would be any conflict with other engagements at that time.

There being no further business, the meeting was adjourned.

Respectfully submitted,
Robert Wilson, Jr., M. D.
Secretary

**MINUTES OF COUNCIL MEETING
COLUMBIA, S. C. 6-10-52**

A special meeting of the Council was held at the Columbia Hotel, Columbia, S. C. at 4:30 p.m. on June 10, 1952. The meeting was called to order by the Chairman, Dr. O. B. Mayer. Members present were Drs. J. W. Chapman, C. N. Wyatt, J. C. Sease, A. C. Bozard, J. P. Cain, L. P. Thackston and R. Wilson, Secretary. Also present were Drs. W. C. Cook, E. M. Dibble and D. F. Adcock.

The minutes of the meetings of Council of May 12, 13, 14, 1952 were read and approved as corrected.

The Chairman called on Dr. Dibble who explained that a vacancy on the State Board of Medical Examiners had been created by the death of Dr. N. B. Heyward, Member at Large and Secretary of the Board. Dr. Dibble stated that it was the opinion of the Board that their duties would be hampered by the lack of a member and requested Council to make a

nomination to the Governor of the State to fill the vacancy. After various questions were asked, Council went into executive session.

After this session Drs. Dibble and Cook were asked to rejoin the meeting and the Chairman informed Dr. Dibble that Council had decided to defer the nomination of anyone at this time but that another meeting would be called to make an interim appointment within sixty to ninety days. At this point Dr. Dibble retired from the meeting.

The Chairman then called on Dr. Weston Cook, who gave a report to Council of the newly formed Grievance Committee, which first met June 9, 1952. Plans were made to carry out the program of this Committee as adopted and the Committee intended to advertise the fact of this new service both to the profession and to the general public. Officers of the Grievance Committee had been elected as follows: Dr. Roderick McDonald, Chairman, Dr. Weston Cook, Vice-Chairman, Dr. J. A. Siegling, Secretary. Council then approved of the plans of the Committee as outlined by Dr. Cook and he retired from the meeting.

The Chairman noted that the time set for the next annual meeting was in conflict with the time previously set by the North Carolina State Association for their meeting next year. Because of the likelihood that a number of exhibitors would be unable to attend both meetings it was voted to change the dates of the South Carolina State Association Annual Meeting to May 4-7, 1953. The Chairman and the Executive Secretary were directed to make the necessary arrangements with the management of the Columbia Hotel, the Chamber of Commerce, and the Richland County Medical Society.

Dr. Wyatt noted the fact that Dr. Thackston, President of the State Medical Association had just returned from Chicago where he had attended a conference of the American Medical Association. It was moved by Dr. Wyatt, seconded by Dr. Sease that the President be reimbursed for necessary expenses for attending the meeting and that council authorize an annual expenditure for this purpose. This motion was passed.

Dr. J. P. Cain noted that members of the Military Affairs Committee often went to some expense notifying men in their district who are about to be called into the service and expressed the thought that they should be reimbursed for this expenditure. We moved that Council authorize the members of this committee to be reimbursed for such necessary expenditures when approved by the Chairman of the Committee, Dr. Owens, and when no funds were available from other sources to take care of this expense. The motion was seconded by Dr. Chapman and passed.

Dr. Chapman noted that a great many members of the House of Delegates had failed to realize the importance of official communications to them and to attend to these matters in detail before a vote came

up on the floor of the House of Delegates. There was some discussion of this but it was felt by Council that little could be done and no action was taken.

At this point Dr. Dibble, along with Dr. David Adcock, returned to the meeting and again requested the Council to act on filling the vacancy on the State Board of Medical Examiners. After their second departure it was felt that no action would be taken at this time but Council would reconvene and consider other possibilities in the not too distant future.

The Chairman of Council then called to the attention of the Secretary the fact that his duties were outlined in the minutes of the meeting of June 1, 1950 and Council directed the Secretary to follow the agreement made at that time between the Executive Secretary and Dr. N. B. Heyward.

There was no further business and Council was then adjourned.

Respectfully submitted,
Robert Wilson, Jr., M. D.
Secretary

MINUTES OF COUNCIL MEETING COLUMBIA, S. C. 7-14-52

Special meeting of the Council was held at the Columbia Hotel, Columbia, S. C. at 6 p.m. July 14, 1952. The meeting was called to order by the Chairman, Dr. O. B. Mayer. Members present were Drs. William Weston, Jr., L. P. Thackston, J. C. Sease, J. H. Gressette, C. N. Wyatt, R. L. Crawford, R. Wilson, Jr. and Mr. M. L. Meadors.

The Chairman announced that the meeting had been called again to consider a nomination for the vacancy on the State Board of Medical Examiners created by the death of Dr. N. B. Heyward. The Chairman stated that Dr. H. E. Jervey, Jr. was not known by many of the members of the Council and had come prepared to meet them. On motion of Dr. Gressette, seconded by Dr. Weston, Dr. Jervey was invited to come in and meet the members of Council. He was introduced by the Chairman to all members and asked a few pertinent questions by the Chairman, after which he retired from the meeting.

The Chairman then called for nominations to fill this office and Dr. W. C. Cook was nominated by Dr. Wyatt, seconded by Dr. Wilson; Dr. H. E. Jervey, Jr. was nominated by Dr. Sease, seconded by Dr. Thackston. It was then moved that nominations be closed.

There was considerable discussion of the wisdom of filling the vacancy at this time, participated in by Drs. Gressette, Wyatt, Wilson, Weston, and the Chairman. Dr. Wyatt withdrew his nomination of Dr. Cook and Dr. Sease withdrew his nomination of Dr. Jervey.

Dr. Gressette then moved that the election of the successor to fill the position of Dr. Heyward as a member-at-large of the State Board of Medical Examiners be deferred until the next meeting of the House of Delegates. This motion was seconded by Dr. Thackston. An amendment was then offered by

Dr. Wilson, seconded by Dr. Wyatt, that the vacancy might be filled at the discretion of Council, before the next meeting of the House of Delegates, if Council so desired. Both amendment and the original motion were then passed.

Dr. David Adcock entered the meeting and answered many questions regarding the matter at hand. Dr. Adcock stated that he could only speak for himself and not as the official spokesman of the Board, and it was then moved and passed that the Secretary be directed to write to the Chairman of the Board, Dr. E. M. Dibble, informing him of the action of Council and requesting an official expression of the desires of the Board of Medical Examiners in this matter.

The Secretary then announced that a contract between the South Carolina Medical Association and the Veterans Administration had been signed on June 30, 1952 and forwarded to the office of the Veterans Administration in Washington. The contract had been signed on advice of the counsel, Mr. M. L. Meadors, and a copy had been filed with him as well as a copy of the fee schedule in effect. The Secretary requested Council to confirm this action at this time and on motion this was done.

The Secretary announced that the exact figure of the profit on the Journal for the past year had been recorded in the minutes of the meeting of June 10, 1952. He announced that note had been made of the instructions of the Chairman in regard to the duties of the Secretary and a copy of the agreement between the previous secretary, Dr. N. B. Heyward, and the executive secretary, Mr. M. L. Meadors, had been obtained from the latter officer. These instructions, entitled "Duties of the Secretary," were:

1. The Secretary shall attend the General Meetings of the Association and of the House of Delegates and shall keep minutes of their respective proceedings. He shall be ex-officio Secretary of the Council. Acting with the Committee on Scientific Work, he shall prepare and issue all programs.

2. He shall be custodian of all records, books and papers belonging to the Association, except such as properly belong to the Treasurer and Business Manager.

3. He shall keep a card index register of all members of the Association.

4. He shall, so far as possible, keep an accurate list of all physicians in the state who are not members of the Association.

5. He shall conduct the official correspondence, notifying members of meetings, officers of their election, and committees of their appointment and duties.

6. He shall employ such assistants as may be designated by the Council.

7. He shall make an annual report to the House of Delegates.

The Secretary announced that an inquiry regarding the eligibility of negro physicians for membership in the Association had been received from the Southern

Conference Fund, Inc. at New Orleans, La. This had been answered to the effect that while there is now no constitutional bar to their membership in the Association such membership is dependent on membership in the constituent units of the Association, the County Medical Societies, each of which is the sole judge of its own requirements for membership.

The Secretary then read a communication from the Secretary of the Arizona Medical Association in regard to the policy of certain Veterans Hospitals in accepting payments from Commercial Insurance Companies for non-service connected disability of veterans and their families. No action was taken on this matter at this time but further information was requested from the office of the Executive Secretary.

There was no further business and the meeting was then adjourned.

Respectfully submitted,
Robert Wilson, Jr., M. D.
Secretary

DEATHS

THADDEUS BENJAMIN REEVES

Dr. Thaddeus Benjamin Reeves, 67, died at his home in Greenville on June 5, after a short illness.

A native of Gray Court, Dr. Reeves received his education at Clemson College and the University of Virginia Medical School in 1914. He spent five years at the Mayo Clinic as surgeon before going to Greenville to practice.

Dr. Reeves is survived by his widow and two sons.

WILLIAM STEELE DENDY

Dr. W. Steele Dendy, 55, died suddenly on June 9 from a heart attack. He was a native and lifelong resident of Pelzer.

Dr. Dendy was graduated from the Medical College of the State of South Carolina in the Class of 1924. He has not only served his community as a physician but as a civic leader as well. He was also prominent in the medical associations in the south.

Surviving Dr. Dendy are his mother, his widow, a son and a daughter.

JOHN HENRY McCULLOUGH

Dr. John Henry McCullough, 82, retired physician, died at a hospital in Newberry on June 28, after several years of declining health.

A native of Newberry County, Dr. McCullough attended the University of Maryland and was graduated from the Southern Medical College, now Emory University Medical School. He had practiced medicine from 1891 until his retirement in 1940, serving as Newberry County physician for a number of years. He was a member of the Newberry County Medical Association, the American Medical Association and an Honorary member of the S. C. Medical Association.

Dr. McCullough is survived by three sons.

ALLEN SMITH BEHLING

Dr. Allen S. Behling, 64, died at his home in St. George on July 14, after an extended illness.

Dr. Behling was graduated from the Medical College of the State of South Carolina in 1912. During World War I he served in the Medical Corps with the rank of Lieutenant. He practiced in St. George for many years until ill health forced him to retire.

Survivors include his widow and one daughter.

NEWS ITEMS

Dr. William P. Beckman, superintendent of the State Hospital, has been named State Director of Mental Health and Dr. William S. Hall has been appointed to succeed him as Superintendent of the State Hospital.

Dr. J. E. Campbell, Jr., of Camden, has begun the practice of medicine in Barnwell and is associated with Dr. Henry Gibson.

Dr. Roy L. Cochcroft, formerly of Newberry, has begun his medical practice at Ridge Spring.

Dr. Samuel Darby Pendergrass, a native of Columbia, has opened offices in Greenwood for the practice of general medicine.

Dr. C. C. Freeman, a Charleston County native, has moved to Williston and is practicing his profession in the offices formerly occupied by the late Dr. A. S. Blanchard.

Dr. Julius Warren Welburn, Jr., who was formerly associated with Dr. "Buck" Pressly at Due West, has moved to Landrum to continue the practice of medicine.

Dr. R. J. Outlaw has opened offices in Saluda for the practice of general medicine. Dr. Outlaw received his elementary education on Sullivan's Island.

Dr. Lawrence D. Frederick has moved to Rock Hill to be associated with Dr. Angus Hinson in the practice of surgery.

Dr. Frank Strait Fairey is now associated in the practice of surgery with Dr. W. B. Ward and Dr. Alton G. Brown of Rock Hill. Dr. Fairey is a native of St. Matthews.

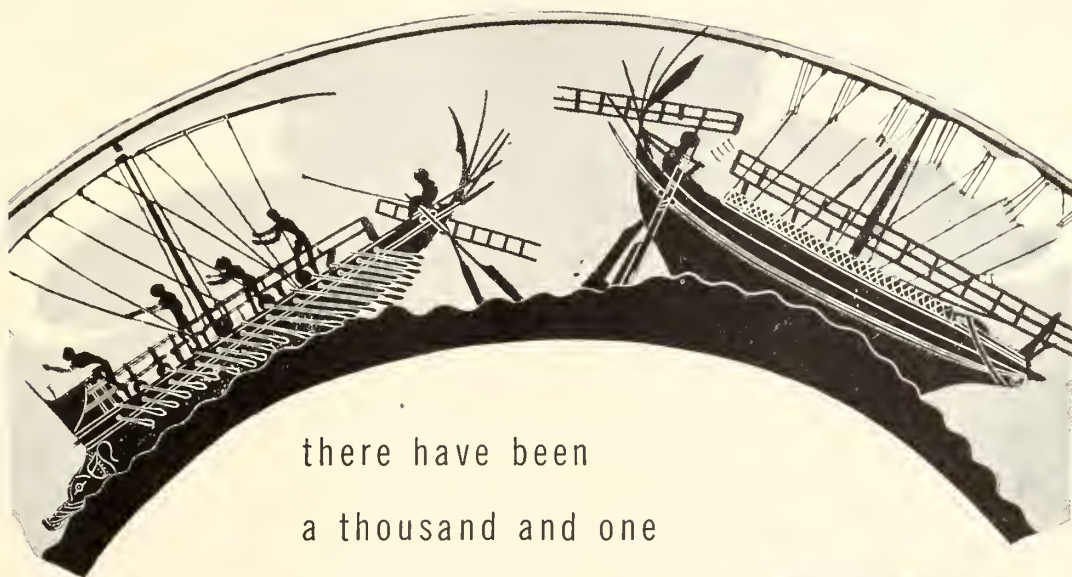
Dr. Charles B. Whitaker, a native Columbian, has opened offices in that city for the practice of general medicine.

Dr. Von A. Long has moved from Prosperity to Newberry where he will continue his practice of medicine.

Dr. Frank L. Culbertson, native of Laurens, and Dr. Malcolm B. Cook, a native of Gray Court, have opened joint offices in Laurens for the practice of general medicine.

Dr. V. J. Hyams of Kershaw, has announced the association of Dr. William McDow. Dr. McDow is a native of Lancaster.

Ever since man went down
to the sea in ships



there have been
a thousand and one
suggestions for
the relief of
motion sickness.



War ship and merchant ship,
about 500 B.C., from painted
vase found at Vulci in Etruria,
now in the British Museum.

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SEARLE RESEARCH IN THE SERVICE OF MEDICINE



Dr. C. Guy Castles has returned to Columbia and opened his offices for the practice of pediatrics.

Dr. A. J. Goforth, Jr., has returned to Greenville after serving with the U. S. Army in Japan for the past two years. He will be associated again with Dr. J. W. Jervy, his practice being limited to otolaryngology and endoscopy.

Dr. V. L. Bauer and Dr. Walter L. Bryant have leased the Johnson Memorial Hospital at Hemingway. Johnson Memorial Hospital was opened by the late Dr. Allen H. Johnson in 1940.

Dr. William H. Bridgers, of Columbia, has received notification of his election as a member of The Harvey Cushing Society.

Dr. John T. Latham has begun practice as a specialist in Dermatology in association with Dr. J. H. Crooks at 200 East North Street, Greenville.

FISKE FUND PRIZE DISSERTATION

The Trustees of the Caleb Fiske Fund of the Rhode Island Medical Society announce the following subject for the prize dissertation of 1952:

"THE PRESENT STATUS OF ANTI-COAGULANT THERAPY"

For the best dissertation a prize of \$200 is offered. Dissertations must be submitted by December 1, 1952, with a motto thereon, and with it a sealed envelope bearing the same motto inscribed on the outside, with the name and address of the author within. The successful author will also agree to read his paper before the Rhode Island Medical Society at its Annual Meeting on May 7, 1953. Copy must be typewritten, double spaced, and should not exceed 10,000 words. For further information write the Rhode Island Medical Society, 106 Francis Street, Providence 3, R. I.

THE TEN POINT PROGRAM

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

PRIORITY III DOCTORS CLASSIFIED

By F. C. Owens, M.D.

(Dr. Owens has been Chairman of the Medical Advisory Committee to the Selective Service System in South Carolina since its organization.)

Local boards have been requested by State Selective Service to mail out classification questionnaires to all Priority III doctors, and upon receipt of these questionnaires to proceed with classification and armed forces physical examination of these doctors.

Receipt by these Priority III men of a card from their draft board that they are in I-A should not alarm the recipient. Notice to take a physical examination does not mean an early call. This examination is to find out which Priority III men are unable to meet the physical requirements.

It might be recalled that the doctors are registered in four priorities. General Lewis B. Hershey, Director of Selective Service, has this to say on the determination of order of Priority of Special Registrants:

"Under section 4 (i) (2) of the Act a special registrant who participated as a student in the Army specialized training program or a similar program administered by the Navy, or was deferred from service during World War II, for the purpose of pursuing a course of instruction leading to education in a medical, dental, or allied specialist category is in the first, second, or fourth order of priority depending upon the amount of active duty he has had in the armed forces or the Public Health Service subsequent to his completion of or release from the program or course of instruction exclusive of any time on active duty spent in postgraduate training. If the special registrant has

had less than ninety days of such active duty, he is in the first order of priority, if he has had ninety days or more but less than twenty-one months of such active duty, he is in the second order of priority, or if he has had twenty-one months or more of such active duty, he is in the fourth order of priority.

A special registrant who did not participate as a student in the Army specialized training program or any similar program administered by the Navy, and was not deferred from service during World War II for the purpose of pursuing a course of instruction leading to education in the medical, dental, or allied specialist category is in the third order of priority if he has had no active service in the Army, the Air Force, the Navy, the Marine Corps, the Coast Guard, or the Public Health Service subsequent to September 16, 1940. If he has had any such active service *at any time* subsequent to September 16, 1940, he is in the fourth order of priority. Such active service includes any type of active service as a commissioned officer or as an enlisted man, and also includes any active service spent in postgraduate training while completing an internship, residency, or fellowship in a medical, dental, or allied specialist category."

Those doctors who are in the first and third priority shall be selected for induction in the order of their dates of birth with the youngest being selected first. Those who are in the second and fourth priority shall be selected according to their length of active duty in the Army, Air Force, Navy, Marine Corps, Coast Guard, and Public Health Service.

There are now listed by State Selective Service three men in Priority I who are subject to the draft. There are listed 22 men in Priority I who have re-

quested commissions but not yet have been called. There are, of course, others in the State who did not register but hold commissions and are subject to call.

Unless conditions change, it is unlikely that any Priority III men will be called up before the end of 1953.

THE CANDIDATES' VIEWS ON HEALTH INSURANCE

Following are public statements of the four Candidates for President and Vice-President, on the issue of Compulsory Health Insurance, or, Socialized Medicine:

STATEMENT BY

GENERAL DWIGHT D. EISENHOWER

Republican Nominee for President

At his press conference in Abilene, Kansas, on June 5, 1952, General Eisenhower was asked the question: "Are you for Compulsory Health Insurance?"

Here is General Eisenhower's reply:

"I am not going to answer too specifically, because what could be in a bill labeled compulsory health insurance? I am not so certain. But I can tell you this: I am quite certain over the years that I was at Columbia, no one spoke out more than I did against the centralization of power in Washington, against bureaucratic government and submitting our lives toward a control that would lead inevitably to socialism . . . I do believe that every American has a right to decent medical care."

In discussing Federal aid to medical education, General Eisenhower said that in private universities we must "support medical education by private means, because if we didn't it would be the first step toward the socialization of medicine, and I am against socialization."

STATEMENT BY

GOVERNOR ADLAI STEVENSON OF ILLINOIS

Democratic Nominee for President

"I am against the socialization of the practice of medicine as much as I would be against the socialization of my own profession, the law If the insurance principle could be brought to bear on these catastrophic illnesses, it would largely eliminate the specter of terror from the average home I am sure that the common objective can be largely realized without the destruction of professional independence.

"Basically, the problem is how to lift people over the costs of major illness. I don't know whether voluntary plans can do the job. I think the new commission on medical needs may well

add some light and remove some heat, enabling us to find a satisfactory solution to this perplexing problem."

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In a press conference on July 30, 1952, Governor Stevenson was asked "whether he saw eye to eye with Federal Security Administrator Oscar Ewing" on the issue of Compulsory Health Insurance.

Governor Stevenson's reply to this question was as follows:

"No, on a number of occasions in the past I have indicated that I thought a new approach was necessary. I emphatically believe that we must find some solution to the problem of catastrophic illness and its devastating expense.

"The President's Commission, of which my friend, Dr. Paul V. Magnuson is Chairman, might well come up with some recommendations and suggestions which would be more palatable, and I am hopefully awaiting the result of the deliberations."

STATEMENT BY U. S. SENATOR

RICHARD M. NIXON

Republican Nominee for Vice President

(Excerpts from address delivered before the seventh annual meeting, Conference of Presidents and Other Officers of State Medical Associations, Atlantic City, June 10, 1951)

"I would like to express my congratulations to the members of this group, and to the medical profession generally, for the very splendid political action the medical profession took in the last campaign leading up to the November election, and in other previous campaigns. As a result of that action, I think we can safely say that there is no chance whatever at this time for any type of compulsory health insurance program to be enacted On the other hand, I think you must recognize, and that all of us who are interested in this fight must recognize, that those who favor such legislation will continue to work fanatically for their cause, in the hope that somehow, sometime in the future, they will be able to accomplish their purpose.

"I think that a great number of people, probably a majority of the people in the country, are convinced that the compulsory health insurance programs which sound so good in theory have not worked out in action in those nations which have tried them.

"I am convinced that the medical profession has taken a very long step in the right direction with its recently announced program of subsidizing medical schools on a voluntary rather than on a government basis. I would suggest also that additional voluntary action is needed (in dealing with) the problem of encouraging wherever possible voluntary health insurance programs. *It seems to me that the objective toward which we should work in the United States is a system where eventually anybody who wants health*

insurance can get it—where those who should have health insurance are encouraged to get it—but where no one in the United States is compelled to take out such insurance against his will. If the profession adopts that objective we will remove by voluntary action the strongest arguments that the proponents of government control of the medical profession have at the present time.

"I believe it is essential that all members of the medical profession recognize that an attempt to socialize any American profession—any American institution—constitutes a threat to all.

"Traditionally, the great accomplishments in this country have not been through government action, but through individual and cooperative action (Our task) is by precept and by example, to prove to the people of the world that a free people, working as individuals, working cooperatively, can solve the problems of our society and can solve them more effectively than can a government."

STATEMENT BY U. S. SENATOR
JOHN J. SPARKMAN

Democratic Nominee for Vice President

"I am in favor of adequate medical attention for the people of this country. However, I have not favored what is generally known as Socialized Medicine.

"I would be opposed to any plan which I thought would, in effect, socialize medicine, and to any medical program which would destroy the relationship of doctor and patient."

The foregoing statement was made by Senator Sparkman in an interview with Mr. Al Goldsmith, editor of *Washington Insurance Newsletter*, on July 31, 1952.

Washington Insurance Newsletter reported that Senator Sparkman strongly indicated he was opposed to the Truman National Compulsory Health Insurance Program, but declined to take a position on specific bills now before The Congress.

In 1949, when the roll was called in the U. S. Senate on President Truman's Reorganization Plan #1, which would have created a Department of Welfare, Senator Sparkman stood with medicine in opposition to this scheme to give Federal Security Administrator Oscar Ewing cabinet status, with increased power over the health and medical affairs of the country.

THE PARTY PLATFORMS

Naturally, both the political parties have included in their platforms an expression on the subject of Health Insurance. Few, if any, of the statements in either document will be of more interest to the doctors generally. The "planks" on the subject, like the foregoing statements of the candidates themselves, are carried for the information of our readers.

HEALTH INSURANCE PLANK REPUBLICAN PARTY PLATFORM

"We recognize that the health of our people as well as their proper medical care cannot be maintained if subject to federal bureaucratic dictation. There should be a just division of responsibility between government, the physician, the voluntary hospital, and voluntary health insurance. *We are opposed to federal compulsory health insurance with its crushing cost, wasteful inefficiency, bureaucratic dead weight, and debased standards of medical care.* We shall support those health activities by government which stimulate the development of adequate hospital services without federal interference in local administration. We favor support of scientific research. We pledge our continuous encouragement of improved methods of assuring health protection."

HEALTH INSURANCE PLANK

1952 Democratic Party Platform

We will continue to work for better health for every American, especially our children. We pledge continued and wholehearted support for the campaign that modern medicine is waging against mental illness, cancer, heart disease and other diseases.

Research: We favor continued and vigorous support, from private and public sources, of research into the causes, prevention and cure of disease.

Medical Education: We advocate federal aid for medical education to help overcome the growing shortages of doctors, nurses, and other trained health personnel.

Hospitals and Health Centers: We pledge continued support for federal aid to hospital construction. We pledge increased federal aid to promote public health thru preventive programs and health services, especially in rural areas.

Cost of Medical Care: We also advocate a resolute attack on the heavy financial hazard of serious illness. We recognize that the costs of modern medical care have grown to be prohibitive for many millions of people. We commend President Truman for establishing the non-partisan commission on the health needs of the nation to seek an acceptable solution of this urgent problem.

AMERICAN MEDICAL EDUCATION FOUNDATION

The following report of the Reference Committee on Medical Education and Hospitals was unanimously adopted by the House of Delegates of the American Medical Association on June 11, 1952:

Your Reference Committee commends the excellent report of Dr. Henderson, President of the American Medical Education Foundation. Your Reference Committee believes that the American Medical Education Foundation deserves and should have the unqualified

support of all members of the American Medical Association. Many of the constituent state medical societies have set up committees for the collection of funds from their members in addition to making a substantial contribution to the Foundation from their own funds. Your Reference Committee urges that similar committees be formed in the state societies where this has not been done. The large sums collected by some state and county medical societies is an indication of what can be accomplished when the importance of this laudable undertaking is brought to the attention of each individual member of the Association. Your Reference Committee believes that those who adhere to the basic concepts of democracy should support the tenets of democracy not only with words but with deeds.

Respectfully submitted,

Edgar V. Allen, M.D.

Charles H. Phifer, M.D.

John J. Masterson, M.D.

Charles G. Hayden, M.D.

On July 31st the Foundation announced a Class "A" grant to each of the seventy-nine medical schools in the United States. A Class "A" grant amounts to \$15,000 for each four-year school and \$7,500 for each two-year school. The total amount to be distributed at this time will approximate \$1,132,500.

The \$15,000 thus allotted to the Medical College of South Carolina will be, we understand, in addition to the \$10,000 donated by the South Carolina Medical Association through the Foundation last year and earmarked for the College.

BLOOD PROGRAM ESSENTIAL

The Bureau of Medical Economic Research of AMA has issued a special release containing reprints of the Report of AMA's Committee on Blood Banks, and the Report on the same subject, of the Reference Committee of the House of Delegates, June 1952. With the view to assisting in the dissemination of the information contained in these reports, and to emphasizing the importance of the efforts of County Societies and individual physicians in carrying out the blood program, we copy the following extracts from the Report of the permanent committee, as presented by Dr. Herbert P. Ramsey, Co-Chairman:

1. *Procurement of Blood for Defense and Civil Defense*—Since the last report high levels of blood collection for defense purposes were maintained through December and until early in this year. There has been a gradual decline through the past three or four months and as of this time plasma processing plants are not being supplied to capacity. From Red Cross data it is learned that for the entire period, Dec. 1, 1950, through April 30, 1952, a total of 2,558,000 units of blood were collected for defense purposes, of which 2,094,000 were collected

through Red Cross regional and defense centers and 464,000 units were collected through cooperating blood banks. In the period July 1, 1950, to March 31, 1952, a total of 209,000 units of whole blood were shipped to the military for overseas use and 2,110,000 units were shipped for the military to plasma processing plants. Approximately only 9% of defense blood obtained in this country was shipped overseas as whole blood although the armed forces publicity program emphasized whole blood for overseas. It should be noted, however, that blood used overseas included also blood procured overseas from the armed forces and civilian donors.

As of March 31, 1952, the facilities in use consisted of 45 regional programs and 15 defense collection centers of the Red Cross and 37 cooperating blood banks. This last figure compares with 33 independent banks reported to the House last December as cooperating. The committee observes that, as predicted in its earliest reports (1948-1949), when the Korean conflict started in June, 1950, the Red Cross as a going concern was ready to start immediately collection of blood for defense. Whole blood was shipped to Korea within 48 hours of the receipt of the first requisition. We felt then and now that the Red Cross is the only present organization geared to the emergency blood needs of defense.

It should be noted that while the minimum primary quotas allocated to the Department of Defense for reserves will be met during this summer, no letdown in the program of defense blood must be permitted, for two reasons: (1) the continuing operational needs of the armed forces and their hospitals must be maintained and (2) a plasma reserve for civil defense of proportions almost equal to that of the Department of Defense is yet to be created. The responsibility of the medical profession and of the public for the protection of our civil population must be fully and patriotically discharged. Nothing must be permitted to disturb the accumulation of the reserve for civil defense.

The Red Cross, the cooperating blood banks, and all other cooperating organizations and agencies and the public should be commended for a program well started and maintained up to this time.

The Report quoted from a directive of the Red Cross as follows: "The Board of Governors (of the Red Cross) recognizes the medical character of the blood program, and has established the policy that this program is to be directed by a doctor of medicine. It is further provided that 'all civilian programs are to be inaugurated only after receipt of the written approval of the county medical society, the hospitals, and the health authority for each county concerned.'"

Continuing, the Report stated:

The committee at this time is embarking on a program of explorations with the Red Cross and

other organizations regarding further evolutionary changes which may contribute toward a smooth working and more permanent national blood program. Much remains still to be accomplished in this field of exploration, and it is expected that a more definitive report will be forthcoming at an early date. As noted in our last report the Red Cross has no plans for increasing the number of its regional centers beyond the 47 originally planned of which 45 are now in operation.

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3. *Misunderstandings and Misinterpretations.*—(A) The inference that the Red Cross makes a profit on blood collected by cooperating blood banks is completely unfounded. Money reimbursed to the Red Cross by the Department of Defense includes the cost of collection, processing, and transportation to plasma processing and shipping centers. In the case of cooperating blood banks the transportation cost has to be paid in addition to the amount paid to the cooperating blood bank. There is no surplus money left with the Red Cross, since all claims are audited by the Department of Defense on the basis of actual cost, and moneys in excess of cost are recovered by the Government. (B) There is no such thing as "reserve areas" in blood procurement. Erroneous representations of this sort made by area Red Cross officials were corrected from the national office.

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(B) The committee has observed the wide variation in service charges in hospitals and blood banks. Local conditions will always cause some variation, but the extremes now observed seem inexplicable. The service charge should cover all costs of the operation including depreciation and expansion reserves, but the realization of profit for the support of other institutional needs should be discouraged. (C) The principle of county medical society endorsement agreed to by the Red Cross should apply also to other blood programs. So-called "service areas" involve at times more than one county and even more than one state. No blood procurement program, no matter by whomsoever operated, should enter a county or state without such county medical society approval. Conversely, physicians of a county medical society should be free to exercise their judgment in the premises without undue pressure

from special pleaders from elsewhere. Furthermore, efforts should be made to avoid friction in borderline areas between two existing blood programs. In these areas cooperative and mutually satisfactory understandings must be had.

(D) Blood program agreements entered into between county medical societies and the Red Cross should be scrupulously honored by both the contracting parties. It would be unfair to the contributors to Red Cross funds to terminate arbitrarily an agreement, predicated upon which the Red Cross had made local capital investments and otherwise carried out its agreement, without providing for indemnification of the capital loss incurred by the Red Cross by the abrogation of the contract. Furthermore, in the public interest no such agreement should be terminated unless it be demonstrable beyond doubt that the community and national supply of blood will be in no way adversely affected by the change.

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7. *State Committees on Blood Program.*—The importance of the formation of state committees on blood program as previously recommended is again emphasized. Your committee has under study plans for strengthening and greatly increasing the usefulness of these state committees. The Committee hopes to announce these plans not later than the next meeting of the House of Delegates.

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The cooperation of physicians in blood banks is greatly needed in making sure that the schedules are accurately filled out and promptly returned.

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Acute Pancreatitis

BY

VINCE MOSELEY, M. D.

&

ANTHONY PAPPAS, M. D.

Unless pancreatitis is constantly thought of in all patients who present themselves with the clinical picture of upper abdominal pain of sudden onset with severe vomiting, the diagnosis is frequently not made; with the symptoms being erroneously attributed to some other cause.^{1, 2}

The anatomical structure of the pancreas and its retro-abdominal location render barium x-ray studies and physical examination findings of little help in most instances of disease of this organ; consequently, the history as to the manner of onset, the character of the pain, and localization are our most important clues from the standpoint of arousing our index of suspicion.

The same pathogenic mechanism, namely enzyme activation and release outside of the acinar structures, is responsible for all types of pancreatitis. The quantities and the duration of action of the extravasated enzymes determine the extensiveness of the lesion.

It may range pathologically in gross appearance from the picture of an acute edema of varying extent to that of severe necrosis with hemorrhage and supuration. Episodes of the milder types of reaction may be of single occurrence or may be recurrent, and the disease process is then designated as relapsing pancreatitis.

There are no broad statistics on which to base an accurate incidence rate for the disease.

The relapsing type is more often seen in men and at a relatively young age as compared with cholecystic disease. The ratio is given as 6 males to 1 female. A large number of the patients develop their first symptoms prior to the age of 30.²

Alcoholism, overeating, and biliary tract disease are often observed to be precipitating factors, and should be inquired into in the history taking. Recently familial hyperlipemia has also been implicated.³

The pathogenesis of acute and relapsing pancreatitis is much more clearly understood than is the

etiology. Infection except for mumps has been discarded as being of only secondary importance. Trauma from surgery or secondary to adjacent viscus perforation is responsible in some instances. The regurgitation of bile via the common channel, between the common bile duct, Ampulla of Vater, and ducts of Wirsung and Santorini, secondary to blockage as from dyskinesia of the sphincter of Oddi, or by a common duct stone, as was first observed by Opie, is a well recognized structural set up for the disease, but one not found to be present in more than 5% of a large number of cases. In our own experience not present in more than 13% of recently autopsied cases. See Table I. Furthermore, this common channel is not the usual anatomical arrangement as has been shown from a large number of cadaver studies.⁴ Partial obstruction of the ducts by squamous epithelial metaplasia or by inspissated mucous has also been recognized as leading to the production of the disease. Arteriosclerosis with pancreatic infarction and arteriolitis, associated with malignant hypertension, and that of other types has also been observed to be the cause in some instances, but by and large, the exact etiology of the disease process remains an enigma in most of the observed cases. Often of direct association in initial attacks, and particularly so in the relapsing cases, are the factors of overeating and alcoholic debauch. Although, it is clear in both instances that the pancreas is subject to excessive stimulation through the mechanisms of secretin, pancreozymin, and vagal stimulation; the factors responsible for the premature activation of the zymogen "trypsinogen" to the active ferment "trypsin," are not clear, in so far as normally, active ferments are not elaborated from the zymogens until they reach the intestinal lumen, where "enterokinase" performs this function. Activation and escape of trypsin from the acinae and ducts into the interstitial tissues appears to be the trigger mechanism which leads to further activation of this and the fat splitting lipase. These together, and depending on the amounts of each, cause the pathological physiological picture.

Perhaps over-stimulation of the vagal reflexes per se is the chief mechanism involved as it can be re-

From the Department of Medicine of The Medical College of South Carolina and the Roper Hospital Charleston, S. C.

produced by mecholyl administration in dogs.⁵ Or, this type of reflexes plus overproduction of pancreaticozym with ecobolic stimulation act together. Thus, overdistended ducts and leakage result from hypersecretion with ductal spasm from vagal influence. With a rise in pH from the secretion of NaHCO_3 into the ducts; trypsinogen can be hydrolyzed slowly to its active form trypsin without the usual intermediation of enterokinase from the duodenal mucosa.

In the case of some alcoholics, malnutrition may play the chief role. It has been shown experimentally in animals made deficient in protein, specifically *methionine*, that ductal and acinar damage occur, and when subject to too vigorous stimulation by the ecobolic hormones the typical changes of acute pancreatitis result.⁴ Hyperlipemia with capillary fat embolism may also play a part in producing the disease in certain individuals; low fat diets have long been recognized empirically as being of aid in management of certain of the relapsing cases.³

The symptoms of acute pancreatitis are usually of dramatic onset. Pain of sudden and severe intensity located in the upper abdomen and radiating through and around the left subcostal area, to the back, and left subscapular area is usual; though at times radiation to the right may be observed. Characteristically the pain is constant and severely agonizing being centered to the epigastric area and left upper abdomen. Continuous nausea, vomiting, and left upper abdominal tenderness may lead one to think in terms of severe gastritis when observed in an individual obviously recovering from an alcoholic debauch. In its more severe forms the prolonged vomiting and the continued intensity of the pain, leading often to vasomotor collapse and with little relief from the usual doses of opiates, will cause one in time, however, to become suspicious of something more serious than gastritis. Adynamic ileus with distension and obstipation are often present. Tachycardia, fever of 100° to 102° and a leucocytosis of 11,000 to 15,000 are common findings. If the enzymatic tissue destruction progresses on to acute diffuse necrosis, rapid worsening of the patient's condition will occur with the development of signs of profound shock. The skin becomes clammy and develops a greyish cyanotic hue. Cullen's sign and the Gray-Turner sign of blue greenish yellowish discoloration about the umbilicus and flanks are late physical signs and are not observed usually before the 3rd to the 5th day of illness. Evidences of tetany due to a loss of blood calcium into the areas of the pancreas and peritoneum, where lipase fat digestion is occurring, are seen clinically much earlier than these classical physical signs. In addition evidences of fat embolism, hyperlipemia of the serum, hemoglobin destruction and derangement of the clotting mechanism of the blood, due to trypsin activity, will be observed early in the severe cases. In addition to hypocalcemia, low potassium and low sodium levels are also often seen in the more severe cases of pan-

creatitis. These electrolyte disturbances may be explained in part as due to the severe vomiting accompanying the attack and also on the basis of renal tubular injury occurring as a result of several factors or combination of factors including shock and other vasomotor reactions reducing renal blood flow. Tubular injury may also result from circulating trypsin, and possibly from precipitation and blockage of the tubules by lipids and hemoglobin. Hyperlipemia and hemoglobineuria may result in the lower *nephron* nephrosis picture,⁶ in severe cases. Although electrolyte disturbances are to be sought for and corrected where possible in management of the individual patient, they are not diagnostic aids, with the exception of hypocalcemia, and in fact may be the source of causing erroneous diagnoses; as for example where such electrolyte shifts are manifested by EKG changes that may lead to a false early diagnosis of myocardial infarction. Obstructive jaundice occurs often from pressure by the inflamed pancreas on the common duct. Liver and splenic enlargement may also occur. Usually there are no residual signs of symptoms after recovery from an acute mild attack of pancreatitis, but with marked destruction or often recurring attacks, evidences of derangement of pancreatic function are to be observed, with the finding of elevated blood glucose values, of the diabetic type, and steatorrhea with bulky stools containing undigested meat fibers and starch. Frequently calcific deposits in the pancreatic area are found on plain x-ray film study. Hepatic and biliary dysfunction signs may likewise occur. The signs of pancreatic insufficiency are insidious in development and are not likely to prove of much aid in the relapsing cases until after many attacks have occurred so that in general in both the acute and relapsing cases our index of suspicion must rest chiefly on the rather nonspecific clinical picture as previously described; paying particular attention to the manner of onset, type, character, location and radiation of the pain combined with one or several of the clinical findings previously mentioned.

When suspected within the first 12 to 18 hours of an attack a determination of the serum amylase value is our best diagnostic aid. If delayed beyond this time a falling off of the concentration of this enzyme may occur to a level below that of diagnostic help. Serum lipase and urine diastase and lipase values are diagnostic aids but not in the acute stage when prompt diagnosis is urgent. This because of the technical delays incident to making these determinations. Until recently there has not been a suitably easily and quickly available supplementary laboratory procedure that was of help in the cases where borderline amylase levels were observed. In December of 1951, however, Innerfield et al published their observation on the rise of the plasma antithrombin titre in individuals suffering attacks of acute pancreatitis.⁵ From Innerfield's reports to date the test appears to be highly specific. Also the test has this to commend in that it can be quickly done and requires only a minimum of apparatus and reagents.

In our own experience to date we have employed this test as an aid in diagnosis in 15 patients. In 5 of these definite confirmatory evidence to support the clinical and amylase titre findings in favor of acute pancreatitis was obtained. In 4 other cases where malignancy rather than pancreatitis was clinically thought to be responsible for the disease picture presented, the test was also of help in that the titres were found to be at control levels or slightly below control levels at the same incubation intervals. In addition in 3 instances which later proved not to be pancreatitis as initially suspected but to be instances of: gastritis, duodenal ulcer, and marginal ulcer; the test was helpful in that the amylase was borderline in these 3 instances whereas the antithrombin titres were normal. Data from the reports recently published by Dr. Innerfield and his colleagues indicate that the antithrombin titre rise parallels roughly the amylase rise in the time at which time it becomes positive, namely within the first two to three hours, but in contrast to the amylase test, the antithrombin titre may remain at diagnostic levels for 3 to 5 days.⁵ In one dog experiment which we personally did, after producing pancreatic injury, the antithrombin concentration was observed to show a continuous rising titre during the first 40 hours post-operatively at which time the amylase titre was beginning to fall. At 72 hours the antithrombin titre was still diagnostically elevated but was beginning to fall. These observations are similar to the previously mentioned clinical observations concerning the positive duration of the test and also similar to the antithrombin titres which have been observed in animal experiments after the injection of known amounts of a single dose of trypsin; this being the enzyme seemingly responsible for this phenomenon of alteration in the blood clotting mechanism in acute pancreatitis.⁵ In addition to these advantages which this test appears to add to our diagnostic armamentarium; the determination of the antithrombin titre is very helpful in suspected cases of pancreatitis in instances where, because of great distress, opiates have been given prior to an opportunity for doing an amylase titre. It is now well recognized that significant elevation of the amylase titre may occur merely from the administration of the various opiates and thus an element of confusion resulting from this source may be quickly cleared up; as the antithrombin titre does not appear to be similarly effected. We have observed no rise in anti thrombin titre in three subjects given X gr. Morphine 1 hour before the test.

In the management of a patient with acute pancreatitis, as has been shown from the results obtained by various clinics in a large series of cases, there seems to be every reason to prefer conservative medical management in patients during the acute state of pancreatitis unless it becomes evident that hemorrhagic necrosis and suppuration have occurred. In these circumstances drainage of the lesser omental area appears to be life saving in a few instances.¹ Operative intervention in the non necrotic cases definitely increases

the mortality.¹ In jaundiced patients simple cholecystosomy has merit in selected cases at times but in general the best results are obtained through non-operative treatment.

Pain relief should be sought by use of agents such as "Demerol" rather than the opiates which cause vagal stimulation and duct spasm and may in themselves cause false elevation of the amylase levels. Anti-cholinergic agents appear to be helpful in this regards, and also are of aid in reducing further enzymatic liberation. Banthine by parenteral injection we have found to be particularly helpful. The use of this type of preparation plus splanchnic nerve block often appears to be more than merely symptomatically helpful. Pain relief is dramatic and an arrest in progression of the process is often observed to result from this form of treatment. After vomiting subsides oral Banthine is very satisfactory for maintenance therapy. The interdiction of food, the use of catheter gastric suction and the adequate replacement of electrolytes and fluids by parenteral routes are well recognized additional measures to be routinely employed. Antibiotic administration of aureomycin or of a combination of penicillin and streptomycin appears to be of value in preventing secondary infection of the damaged gland.

After recovery a diet calculated to contain no more than 80 to 90 grams of fat would seem helpful in some instances to guard against recurrences. Alcoholic beverages should be strictly interdicted and if any insular deficiency becomes evident insulin replacement should be instituted. At times whole pancreatic gland extract will be necessary to provide for proper intestinal digestion. Methionine and choline should be given for their protective value to the pancreas and liver. There is gradually building up a mass of evidence pointing to the metabolic interdependence existing between the pancreas and liver and proper attention to these aspects are of the utmost importance in a preventive sense. Antiacids are advisable so as to reduce secretin stimulation produced by HCl.

Where disease of the biliary tract is evidently of importance interval surgery with such measures as cholecystectomy, sphincterotomy, and choledochojunostomy may be needed.

Where these measures fail, pain relief and prevention of narcotic addiction can be achieved by surgical excision of the sympathetic pain pathways. An adequate trial with Banthine and the dietary measures outlined will often, we believe, prove adequate in minimizing relapsing cases. Perhaps some of the other ganglionic blocking agents may prove, with further study, to be even more effective.

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TABLE I

Patient	Etiology	Biliary Disease Present	Common Channel Present	Clinically Diagnosed
C. M. age 40	Alcohol	NO	NO	NO
C. F. age 46	Toxic Goitre, (Nutritional?)	NO	NO	NO
C. F. age 4	Ascariasis	NO	NO	NO
C. M. age 10	Rheumatic Fever (Nutritional?)	NO	NO	NO
W. F. age 25	?	NO	NO	NO
C. F. age 20	Duct Fibrosis of? cause	NO	NO	NO
C. M. age 40	Overeating (Fish Fry)	NO	NO	NO
W. M. age 40	?	NO	NO	NO
W. M. age 35	?	NO	NO	NO
C. F. age 45	Arterial insufficiency? Associated with an abdominal aneurysm (Luetic).	NO	NO	NO
W. M. age 65	?	NO	NO	NO (Misdiagnosed "coronary" from false EKG Changes)
W. M. age 50	Arteriosclerosis with infarct.	NO	NO	NO
W. F. age 59	Bile Reflux	YES—stones	NO	NO
W. F. age 45	Bile Reflux	YES—stones	YES	NO
W. M. age 65	Bile Reflux	YES—stones	NO	NO
W. F. age 60	?	NO	NO	YES
W. F. age 45	Bile Reflux	YES	YES	NO

Table to illustrate the causes of acute pancreatitis as observed in 17 autopsied cases; indicating the relative infrequency of Biliary tract disease as an etiological factor.

Electro Shock Therapy and Lobotomy Program in the State Hospital

JOE E. FREED, M. D.
AND
EDWARD M. BURN, M. D.
Columbia, S. C.

Electro shock therapy and prefrontal lobotomy operations are not new to you. All of you have had patients who have had these treatments, who returned to their responsibilities at home and came back to you as their private physician.

Since these therapies are usually given in the setting of a psychiatric hospital, we felt that you would be interested to have some of our observations to help acquaint you with our present concept of electro shock and lobotomy.

History of Electro Shock Therapy

The idea of inducing convulsions with electric current for therapeutic purposes in man followed the experimental study of convulsions in animals particularly in dogs. Historically, it is of interest to note that Scribonia Largo wrote a treaty on therapeutics about the year 45 A. D. in which he tells of the treatment of headache by the use of a live torpedo-fish applied to a sufferer's head.

Electric shock treatment was first developed and used on humans in Italy by Cerletti and Bini¹ in 1938. This idea actually had been conceived some years before.

This treatment produces unconsciousness followed by confusion and is accompanied by a retrograde amnesia which may be so complete that the patient does not recall treatment.

Description of the Electro Shock Machine

There are a number of different models of electric shock machines on the market, some of them are quite complex and expensive. The model which is perhaps the most rugged and satisfactory for general purposes is one quite similar to that originally designed by Bini. It⁷ consists primarily of a stopwatch for time regulation to fractions of a second and of devices for measuring and regulating the current. Alternating current from electric light circuits having a frequency of 50 to 60 cycles is used. A voltmeter regulates the voltages applied, usually from 70 to 130 volts. Electrodes are applied to the patient's temples after an electrode paste has been rubbed on. The exact voltage and time of current passage varies widely and has to be determined more or less on an individual basis. It has been found that the actual amount of current passing during the treatment ranges from 200 to 1600 milliamperes.

Newer technics and machines have appeared, such as electronarcosis, brief stimulus, and electrostimulatory nonconvulsive treatment. The results from these therapies are approximately the same as the results obtained from the standard machine.

Theories of Electric Shock Therapy

Many theories have been offered to explain the action of electric shock therapy. One writer⁴ on this subject has collected the surprising number of 50 different theories. In reviewing 50 of these theories the author points out that many great drugs and curative methods began (and in some cases remain) as empiricals. In many of our psychiatric conditions we do not know the etiology and, therefore, cannot expect to understand the mechanisms of a treatment which was found on strictly empirical grounds. Nolan D. C. Lewis states that, "at the present time there is no theory as to the nature of shock treatment sufficiently comprehensive to be taken very seriously."

The therapeutic action of electric shock therapy is explained by some authors on an organic basis, others believe that the benefit is effected on a psychogenic basis. Among the organic or so called "somatic" theories are the following:

1. Biological antagonism between schizophrenia and epilepsy.
2. Weakening of association tracts.
3. An effect on brain metabolism, and oxygen utilization.
4. Forms a "hormone," lactic acid, or similar substance.

Some of the psychogenic theories which have been advanced include:

1. Satisfies a masochistic drive, serves as atonement.
2. Releases tension and anxiety.
3. Amnesia is healing factor.
4. Brings personality down to lower level thus facilitating adjustment.

Indications for Electro Shock Therapy and The Results Obtained

The chief indications⁶ for electro shock therapy have been listed frequently yet there remains much confusion and disagreement. EST is almost specific in its effect on depressions. The manic depressive, in-

volitional, and old age depressions react almost equally well and usually only four to eight treatments are required in these cases. It is frequently overlooked that moderate depressions are a much greater suicidal risk than the advanced cases where there is no initiative left. Delaying treatment in such cases is negligence. The general practitioner should bear in mind that this is the patient who is mildly depressed, tired, sleepless, loses weight and begins to complain of vague physical symptoms. To these patients general medical measures and sedatives are of no avail, including the hormone substances which are still widely used in involutional depressions. With electro shock therapy the rate of remissions in the manic depressive depressions varies between 80 to 100 per cent. The episodic recurrences of the psychosis can not be prevented. In an attempt to prevent further episodes several investigators⁸ have introduced the practice of giving prophylactic electric shock treatments at monthly intervals and have obtained good results.

In the manic phase of the manic depressive psychosis the immediate remission rate with electro shock therapy almost equals that of the depressed phase. At times, however, more intensive treatment is needed.

In pure involutional melancholia the prognosis is not influenced by the duration of the illness. Paranoid involutionals show a much less favorable response. Consequently the two groups have to be dealt with separately. Kalinowsky, who has done extensive research in this field, has found that over 85 per cent of involution melancholia patients recovered and only 45 per cent in the paranoid group.

Senile or pre-senile depressions respond well to shock treatments. The results in these older patients will depend on how far the arteriosclerotic or senile brain changes have determined depressive symptoms. The simultaneous presence of some arteriosclerotic brain changes in a patient with an affective psychosis does not completely exclude the possibility of a favorable result.

Schizophrenia is the disease for which convulsive therapy as well as insulin coma treatment was originally introduced. Applied adequately EST gives 60 to 70 per cent good remission during the first six months of illness in patients with schizophrenia having an acute onset. The remission rate remains satisfactory up to one year. Early treatment in schizophrenies is imperative. Improvement is very much lower in patients who have an insidious onset of the disease.

Sandison (London) and others believe that EST does not produce better results in schizophrenia than those arising from spontaneous remissions in the hospital. They do agree, however, that the acute phase is cut short. Therefore, the length of the illness is shortened and the patient becomes more manageable.

Of the sub types of schizophrenia the catatonic

excitements respond best. Next are the acute paranoids. The catatonic stupors respond rather dramatically to the first few treatments but unfortunately they relapse. The poorest results are obtained in the hebephrenic type of schizophrenia. Complete failure is often encountered in the late paranoids and similar syndromes in the middle aged group.

We routinely give our schizophrenic patients twenty treatments, and these are administered every other day. In an acutely excited patient we may give three to four treatments within twenty-four hours. The number of treatments a patient is to receive is decided before treatment is started. If the patient relapses after twenty treatments, ten more are given. If a second series of ten treatments is necessary, we begin to think seriously of recommending a transorbital lobotomy. Those patients showing temporary response to EST are good candidates for lobotomy.

The largest group of psychiatric patients who do not respond to electro shock is represented by the psychoneuroses. Most criticism of EST results from its indiscriminate use in these cases. Many neurotics react badly to the memory impairment, and complain of it, long after psychological tests have shown no actual impairment. Conversion symptoms sometimes disappear, as they may do after any impressive treatment, but more often side effects such as headaches, muscle pain, and so on, are added to the patient's list of complaints. The group of neurotics where EST is indicated is the reactive depressions. They respond as well as other depressions but the basic neurotic pattern remains after treatment has been concluded. In obsessive compulsive neurotics the results are uncertain. The emotional tension accompanying their compulsions and obsessions is often lessened for a while and although these symptoms may be partially obliterated by the amnesia, the symptoms in most cases return sooner or later with the same intensity.

Most authorities agree that electro shock therapy per se is of little or no value in the treatment of drug addicts, alcoholics, and psychopathic states. Where these conditions are the symptoms of an underlying psychosis then electro shock therapy would be definitely indicated.

We frequently use electro shock to quiet a disturbed patient who is suffering from an organic psychosis such as general paresis, epilepsy, or cerebral arteriosclerosis. Usually four to six treatments is all that is necessary to make these patients more manageable.

There are practically no absolute contra-indications to electro shock therapy. It has been used successfully in very disturbed patients who have recently suffered a cerebro-vascular accident or coronary occlusion. It is no longer believed that advanced pulmonary tuberculosis is a contra-indication. Fatalities are very rare and when they do occur it is always on a cardiovascular basis. Usually an embolus from an old lesion finds its way to the heart or lungs. Fractures as a re-

sult of shock occur infrequently and when they do are chiefly compression fractures of the dorsal vertebrae which require no special treatment.

Let us now consider the operation prefrontal lobotomy. Some writers prefer the term "leukotomy" which means a cutting of white fibers. The terms are synonymous. The term "psychosurgery" applies to surgery of the intact brain for the purpose of relieving mental abnormalities.

History of Prefrontal Lobotomy

The operation of lobotomy was first described by a Portuguese Psychiatrist by the name of Egas Moniz. In 1936 he reported dramatic changes in mental patients subjected to an operation on the frontal lobes. This work stimulated Freeman and Watts of Washington, D. C., to institute psychosurgery in this country. These pioneers faced considerable criticism both from psychiatrists and neurosurgeons. Some psychiatrists were extremely opposed to the operation saying it was "too drastic," that it "admitted defeat" or that it destroyed brain tissue and altered the personality of the individual. Many neurosurgeons were opposed to an operation in which brain tissue was divided blindly. Much of this opposition has subsided with the convincing evidence that surgery of the frontal lobes can bring relief to many patients suffering from mental disorders.

Theory of Lobotomy

Many of you have wondered about the principles behind this operation. The frontal lobes are the parts of the brain most concerned with behavior and personality. Large areas may be removed from other parts of the brain and will cause alterations in behavior, but these depend, for the most part, upon the impairment of specific functions such as speech, motor power, or vision to one side. Even a whole hemisphere may be removed for a tumor and the patient is little the worse for it, psychologically speaking.

Mental tests fail to reveal either positive or negative symptoms after removal of considerable portions of both frontal lobes. Either present psychological tests are not sensitive enough or the powers of compensation in the remaining parts of the frontal lobes are so great that no measurable defect remains.

Most of the functional psychoses and neuroses seem to begin in the realm of fantasy. This is easy to understand when we realize that the self-conscious inadequate individual developing a mental disorder feels he can no longer compete with reality and resorts to day dreams retreating into a world of fantasy, a world which he can control. There is a theory that the area concerned with fantasy is in the frontal pole of the frontal lobe. Therefore, to separate this frontal pole, theoretically, should improve the mental disorder.

There are at least five different psychosurgical procedures. Some attack the gray matter of the frontal lobe, one attacks directly the nuclei of the thalamus, and the other forms of the operation are directed against the intercommunicating pathways between the thalamus and the frontal lobe.

The operation is concerned with disassociation of the emotions from abnormal ideas. Theoretically the center for our emotions lies in certain nuclei of the thalamus. When we develop an abnormal idea, we most surely will develop an emotional component to the idea. The idea or fantasy originate in the frontal lobe; the emotion of rage, fear, or anxiety find their origin in the thalamus. The fronto-thalamic tract is the highway carrying impulses back and forth as new ideas precipitate new emotions. When this pathway, the fronto-thalamic tract, is cut in a psychosurgical operation the patient is relieved of much of his abnormal behavior. He may still have his delusions but since there is no longer an emotional component attached to them he is not disturbed by them. As one patient said to me, "I hear voices at times but I don't pay any attention to them anymore."

Behavior Manifested by The Lobotomy Patient

Let us consider the behavior² of the operated patient. The lay press has done much to mislead and confuse the public about the lobotomized patient going so far as to call these individual "Zombies."

The first trait one notices about their behavior is their carefree attitude. A second characteristic is their insensitiveness to criticism and this includes self-criticism. You may ask if he has any faults, he will say he has plenty, but cannot mention a single one when asked to do so. Another trait is inertia. They are more on the placid side. Patients are more apt to take their diversions sitting down. These like all other symptoms have a quantitative aspect. Closely allied to inertia is the symptom of carelessness. Less time and thought are spent upon beauty treatments and cosmetics, more upon reading and playing solitaire. They lack the urge to creative endeavor. They do not strive to find quicker or more effective ways of doing things but do routine things well. The patient is easily provoked to outbursts of anger sometimes on slight provocation but these episodes are of short duration. Rarely does he hold any grudges. It is important that this new behavior pattern be understood and anticipated by the family.

One writer says that the typical discharged leukotomy patient is "cheerful and contented, not worrying, having a high opinion of himself and his abilities, active and restless, with varied and variable interests especially for light entertainment and superficial past times, easy going and sociable but without depth of feeling and with little sympathy or consideration for others, and without regrets. He may also be head strong and tends to quickly passing outbursts of temper."

Indications For Lobotomy

The prefrontal lobotomy if applied to the right type of patient is a valuable means of saving patients from the misery of mental illness. Misconceptions such as the belief that only hopeless deteriorated schizophrenics should be treated by lobotomy are as fallacious as the total rejection of the operation for reasons of principle.

The first requirement in each case⁵ to be selected for prefrontal lobotomy is that the patient has received adequate treatment with non-surgical methods. We insist that such be given before the patient is accepted for the operation. Secondly, we made it routine in selecting cases to gather all the possible information about the patient's personality prior to his illness. Unpleasant traits will become magnified after lobotomy. On the other hand a pleasant well-adjusted personality minimizes the threat of post-operative difficulty.

It is difficult to explain the possible outcome of the operation to questioning relatives. We never state the possibility of full recovery. It requires considerable understanding and judgment to give the relatives a true picture and yet not to discourage them from consenting to an operation which is considered to be in the interest of the patient. Two factors come to our help. We can state that the operation never makes the patient worse, and we can offer hope for some relief of the patient's mental suffering.

The largest although hardly the most successful operated group is represented by schizophrenia. The sub types of schizophrenia vary widely in their response to lobotomy. Catatonic excitements are excellent subjects for the operation. In the catatonic stupors our experience is not encouraging. Hebephrenics are rarely suitable for operation. They show little emotional responsiveness. They usually should be rejected. Paranoid schizophrenics represent the group to which the best results can be expected. These are the best prospects for the operation because the basic schizophrenic symptoms often occur late or not at all and the picture often is limited to delusions with adequate affect. The personality remains well preserved as it does also in the rare cases of true paranoia. Both groups do not respond to shock therapy and lobotomy is strongly indicated. The relatives should be told that the delusions and hallucinations may continue but that the patient is no longer troubled by his ideas.

The affective disorders of manic depressive psychosis and pure involutional melancholia should not be freely accepted for lobotomy. These cases should not be endangered by the personality changes of the lobotomy as long as the episodes of depression or manic behavior can be easily controlled by a relatively few shock treatments. Most patients with involutional psychosis unresponsive to shock therapy have paranoid symptoms. In them the operation should be recommended. The same is true in cases of severe hypochondriasis.

Far superior to the results obtained in schizophrenia are those in the severe psychoneuroses. Good results can be expected in the obsessive-compulsive type. The suffering of these patients is often comparable to, if not greater than, patients with painful physical diseases. Neurotics, who did not benefit from psychotherapy, should be accepted for the operation if they are total invalids, suffer severely, and are unable to lead a normal life.

Personality disorders such as psychopathic personality are occasionally considered for lobotomy. It should not be overlooked, however, that the operation can never change personality traits. A psychopath who tells lies will continue to do so after the lobotomy with even less inhibitions.

Dangerous tendencies justify the operation occasionally in such conditions as mental deficiency, psychomotor epilepsy, and other organic syndromes.

Results Obtained

Statistics from two separate state hospitals with similar problems as ours will be reviewed. In the Connecticut Cooperative Lobotomy Study, Friedman and Moore³ report on the status of 254 prefrontal lobotomy patients at the end of the second post-operative year. These patients are compared with 100 control patients observed for the same period of time. The controls had been selected for operation but for some reason permission was not obtained. These writers report 50 to 60 per cent of their patients exhibited significant improvement after operation with a discharge rate of 37 per cent. In contrast to the operative group only 3 per cent of the control group exhibited any improvement and this improvement did not compare to that of the operative group. Only 2 per cent were able to leave the hospital.

The other statistics are also from a state hospital using transorbital lobotomy. What Wilson and Pittman⁹ say could well be said of the South Carolina State Hospital. They say, "our state hospital is overcrowded and inadequately staffed with trained personnel. It is unlikely that if sufficient funds were available for construction it would be possible to obtain sufficient qualified personnel to man the wards. It is, therefore, not only a psychiatric problem, these disturbed patients, but also one of economics." Two-hundred cases of chronically disturbed patients were selected for transorbital lobotomy operation. They were considered hopeless as far as any degree of improvement was concerned. Practically all had been confined to small seclusion rooms for periods of time up to twenty years, with an average of eleven years. After transorbital operation they report 26 patients out of the hospital, 90 patients improved so that they became useful in their environment, and some improvement noted in 22 other patients. About one third of the patients were unimproved.

The first prefrontal lobotomy operation was performed at the South Carolina State Hospital in May, 1947. Five years have now elapsed. During this time we have learned a great deal about the operation, the proper selection of patients, and the results we might expect. The first operations were done by the so called "open" method. The open operation was a prolonged, painstaking laborious procedure.

For the past two years we have been doing the transorbital lobotomy since it offers many advantages both to the patient and the hospital personnel. Then too, the open operation can always be done at a later date if it is felt the transorbital lobotomy did not accomplish the desired effect.

In speaking of the two operations, Dr. Freeman has noted the following from his series of cases, "the overall picture is pretty much the same for the two types of operation, 68 per cent of the patients being able to live outside of institutions after transorbital lobotomy as compared with 70 per cent after prefrontal lobotomy. The minor operation is less successful in dementia praecox cases but more successful in other types of mental disorder."

At the South Carolina State Hospital during the past five years we have performed 210 lobotomy operations. Of this number 124 were of the transorbital type. Approximately 70 patients are at home, some for over a year. About 35 to 40 patients could be released but there is no one to take them and give them some general supervision and guidance. No patient was made worse by operation but 35 patients failed to show any improvement. The remaining patients in our series roughly 40 per cent have shown varying degrees of improvement. They are no longer kept in seclusion, they are now able to make a satisfactory adjustment to their environment and many have been moved to more desirable wards. It is also to be considered improvement from an economic standpoint to relieve the destructive tendencies of a disturbed patient who may destroy as much as \$25.00 worth of bedding and clothing in a single day.

Complications

In our series of 210 cases the total operative mortality was 4 cases. There have been no deaths in the transorbital lobotomy cases.

Two complications always anticipated are hemorrhage and infection. We have had two cases of hemorrhage and in each of these cases the bleeding was controlled by open operation and the patients survived.

The only other complication is post-operative convulsive seizures. These rarely occur following transorbital lobotomy. An incidence of 3-10 per cent was reported with prefrontal lobotomy. These responded well to the usual anti-convulsant drugs.

Conclusions

1. Although the underlying mechanism and theory of electro shock is not understood, it still remains the most important single tool of psychiatry today.

2. Experience with this therapy during the last twelve years has indicated its value as well as its definite limitations.

3. In the majority of cases EST produces symptomatic relief but reoccurrences of the mental illness are to be anticipated.

4. The lobotomy operation is concerned with disassociation of emotions from abnormal ideas.

5. In selecting patients for lobotomy careful consideration must be given to their prepsychotic personality structure. The operation tends to remove inhibitions and undesirable traits of the personality may be exaggerated.

6. Results with lobotomy at the S. C. State Hospital compare favorably with other similar institutions.

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The General Practitioner of the Future

PAUL WILLIAMSON, M. D.
Memphis, Tenn.

(The University of Tennessee has a General Practice Department completely staffed by general practitioners. In this department an effort is being made to train young men and to interest them in the field of general practice.)

Dr. Paul Williamson is the director of this project and we are glad to publish this paper of his which presents his views of the general practitioner of the future. (Editor.)

During the past ten years there has been an increasing interest in the family physician. The American public has clamored for the return of the general practitioner of fifty years ago and has made the profession take some cognizance of the fact that the front line of medicine is the work done by the family physician.

With renewed interest in his field of duties and in his training, it seems probable that there will be developed a new type of general practitioner. His field of interest will probably be much broadened and it is entirely possible that specific training for general practice will become a part of the medical curriculum, either at the undergraduate or the postgraduate level. This, I believe, is one of the wisest moves made by the profession in the past hundred years.

A definite trend of thought in and about general practice is becoming more apparent every day. In this brief article, I shall attempt to outline these thoughts as they have been expressed to me by leading medical thinkers and by active general practitioners.

To begin with, the general practitioner is ideally suited to practice psychosomatic medicine. His very position with the family gives him an increased insight into family and individual problems, an insight that is not available to the highly specialized physician except through the medium of long and tedious history taking. The family physician is in a position to be a family friend and advisor, whereas the highly specialized physician is not.

Leading medical philosophers are giving much thought to the broadening of the scope of general medical practice. It is undeniably true that medicine casts its emphasis on the acute phase of a single disease. Any thinking physician will admit that it is impossible to satisfy the public by concentrating only on disease.

More important than all our medicines and surgical techniques at the moment are the myriad personal elements which affect disease. It is true that the basic irreducible unit of medical practice is the person and not the particular disease that he has. With increasing emphasis on this, one then comes to the problem of how to emphasize this personalized medicine to the profession.

There can be but one answer to this and that is to train general practitioners as 'personal physicians' and to emphasize as a major portion of their training the humanities as applied to medicine.

Another area in which the scope of medicine will probably be broadened is the community service facet of medical care. It is probable that the doctor will be devoting a goodly portion of his time to community health problems, both organic and psychic. The prevention of disease will become just as major in his thinking as the cure of already existing disease. One might almost think of the general practitioner of the future as a community health executive.

Should this come to pass, the general practitioner is the only possible man who could carry on the duties of community health along with curative treatment of disease. Granting this is so, the general practitioner of the future will probably have a broadened view of the problems of health and disease. Much more so than the physician we train at present. It is unfortunately true that many of the graduates of our medical schools are simply superbly trained medical technicians with little or no background in the humanities and little or no understanding of the broad philosophies of medicine.

It is the conjecture of many leaders of medical thought—and I heartily agree—that the general practitioner of the future will be specially trained for his function in the community and that, in addition to his training in the basic fundamentals of disease he will be given a broad background in the philosophies of medicine, and that he will be trained as far as is possible in the humanities.

In order to grant the warm human understanding which is an essential part of the personal physician's work, the doctor must have had experience with people as they are. He must know the emotional reactions of people and what to expect from these emotional reactions, and he should know in greatest detail the common behavioral patterns which we see so frequently.

It is surprising the number of physicians who do not know these things even though they have been in practice for many, many years. We feel that this training in the humanities is an essential part of medical education and that medical schools in years to come will set up human laboratories designed to give students experience in the behavior of people.

The general practitioner of the future will probably be the key man of all medical effort. He will be especially trained for this job and will have as his relation to his patients a place similar to that occupied by the splendid family doctors of half a century ago.

It is my opinion that only genuine progress can come from this expanded field of general practice, and I believe that it is the duty of the individual general practitioner over the United States to take stock of the work he is now doing and to see if he does not believe that the field of general practice can be much extended.

CANCER

Edited by JOHN C. HAWK, JR., M.D., Charleston, S. C.

REPORT OF ACTIVITIES OF STATE-AID CANCER CLINICS—1951

FRANK L. GEIGER, M. D.
Columbia, S. C.

Chief, Cancer, Heart Disease and Tuberculosis Services,
Division of Disease Control, State Board of Health of South
Carolina, Columbia, South Carolina.

The early diagnosis of cancer, followed by prompt treatment and adequate follow-up of the treated case so that any cancer recurrence will receive prompt consideration, are the objectives of the Section of Cancer Control of the State Board of Health of South Carolina. To determine the progress toward these objectives, yearly statistical studies are made of patients referred by private physicians to the nine state-aid cancer clinics. The following report covers some of the pertinent facts regarding the cancer patients admitted to the cancer control program from January 1, 1951 to December 31, 1951.

A total of 825 new cancer patients (475 white and 350 Negro patients) received treatment in the cancer clinics during the calendar year 1951. An additional 2,600 cancer cases who had been admitted to the clinics in previous years were seen periodically during the year.

Of the 825 new cancer patients, 407 or 49% were found to have localized lesions upon admission for treatment. However, when the 194 cases of localized skin cancer were excluded from the compilations, the 407 cases of early cancer dwindled to 213, and the percentage of early cases decreased from 49% to 35%. The 213 early cases consisted of 82 white females, 34 white males, 67 Negro females and 30 Negro males.

By eliminating the 211 persons with skin cancer from the total of 825 new patients, it was determined that 614 persons with cancer of sites other than the skin were treated in the clinics. An analysis of these 614 cases by stage, color and sex showed that 99 or 56% of the white females, 54 or 63% of the white males, 143 or 70% of the Negro females and 77 or 74% of the Negro males had regional or diffuse metastases when referred to the cancer clinics. These figures are disappointing, but nevertheless they are factual.

The following table gives an analysis of the 12 most common types of cancer treated in the clinics:

In studying the above table it will be noted that more cases of skin cancer were treated than any other type of malignancy. As is well known, skin cancer occurs almost exclusively in the white race. Of clinic cases with this malignancy, 198 were white patients

as compared to only 13 Negro patients. One hundred and ninety-four or 92% of these cases had localized disease and were curable.

Among females attending the clinics for the first time, more were suffering from cancer of the cervix than cancer of any other site. Since early cancer of the cervix is curable in eight out of ten cases, it was stimulating that 56% of the white females had no extension beyond the cervix. Unfortunately this percentage was reduced to 36% in Negro females.

More and more physicians are including speculum examination of the cervix in the routine examination of their female patients. A smaller number are including cytological studies of cervical smears as an adjunct to cervical inspection. These procedures are uncovering a number of early cases of carcinoma of the cervix. The Cancer Commission and the State Board of Health are interested in inaugurating a state-wide cytological service to which individual physicians and the cancer clinics may refer specimens obtained on indigent patients suspected of having cancer. The matter of such cytological services is to be discussed within the next few months with representatives of the South Carolina Society of Pathologists.

Eighty-five females with carcinoma of the breast were admitted to the cancer program in 1951. In 25 or 29% of these patients the malignancy was limited to the breast. The percentage of localized breast cancer was higher in white females than in Negro females, that is 43% as compared to 17%. Since a "lump" in the breast can readily be felt if systematically searched for by the patient, physicians should acquaint their mature female patients with the technique of breast self-examination. The physician and the patient will be amply repaid by the discovery of even one unsuspected, early carcinoma of the breast by this simple procedure.

Cancer of the alimentary tract kills more South Carolinians than cancer of any other site, as it produces unusual symptoms only when advanced. Therefore, it is not surprising that only 12 or 15% of the 80 cases of cancer of the esophagus, stomach and rectum were early when diagnosed. Any patient past 45 years of age with the complaints of dysphagia, indigestion, severe anemia, diarrhea alternating with constipation and or rectal bleeding should be suspected of having cancer of the alimentary tract until proved otherwise.

The incidence of primary bronchogenic carcinoma is definitely increasing. Further, this type of malignancy is of mounting importance as a cause of death in the males of this state. Consequently, it is dis-

treating that only 2 or 7% of the 26 patients with cancer of the respiratory system had localized disease.

All males past 50 should be encouraged to have annual chest x-rays, as x-ray shadows suggestive of early carcinoma of the lung usually are present before the individual presents symptoms. Clinically, it is wise to remember that every wheeze is not asthma and that recurrent attacks of pneumonia or pneumonitis in older persons are very suggestive of bronchogenic carcinoma.

This study reflects an encouraging note in relation to prostatic carcinoma. The malignancy was confined to the gland in six out of every ten cases treated by the clinics. More early cases of carcinoma of the prostate will be diagnosed when physicians make it a point to palpate the prostate of their male patients, especially in those who are past 50 years of age.

Each year, cases of advanced carcinoma of the penis are admitted to the clinics. Forty per cent of the cases treated in 1951 had regional or distant metastases. This fact is hard to understand since the lesion can be seen and felt by the patient from the beginning, and there is, therefore, no good excuse for this disease to reach an advanced stage before coming under medical care. As a matter of fact, carcinoma of the penis could probably be prevented from ever occurring if all male infants were circumcised soon after birth. The attainment of this ideal situation demands the education of the expectant mother and father in regard to the importance of this procedure.

This report clearly demonstrates that in 1951 the majority of cancer patients already had advanced disease when they were referred to the state-aid cancer clinics. This was especially true of the Negro patients.

THE PRESIDENT'S MESSAGE

THE DOCTOR'S POSITION IN POLITICS

- (1) There is an attack being made on the present type of the practice of medicine.
- (2) A very serious emergency situation now exists.
- (3) The doctor must exercise his position as a citizen and his influence in the community if he expects to survive.
- (4) He should very carefully analyze the position of the presidential candidates on matters vital to our country and, after careful and prayerful consideration, he should courageously vote as his conscious dictates and he should see that as many other citizens as possible do likewise.

Lawrence P. Thackston, M. D.

MEDICAL COLLEGE OF SOUTH CAROLINA
POSTGRADUATE SEMINAR-INTERIM MEETING OF THE S. C. ACADEMY
OF GENERAL PRACTICE
FOUNDER'S DAY PROGRAM
November 5-7, 1952
POSTGRADUATE SEMINAR

Wednesday: November 5, 1952

A. M.

- 8:30—Registration & Greetings
 9:00—Management of Cardio-Vascular Emergencies Dr. John A. Boone
 10:00—Management of Obesity Dr. Robert Wilson, Jr.
 11:00—Cirrhosis of the Liver Dr. Vince Moseley
 12:00—Management of Pulmonary Embolism Dr. C. de Saussure

P. M.

- 2:00—Intestinal Obstruction due to Ascaris Drs. M. W. Beach & Margaret Jenkins
 3:00—Behavior Problems Dr. J. J. Cleckley
 4:00—Resuscitation of the Newborn Drs. C. D. Conrad & John M. Brown
 5:00—Pathologic Conference Dr. John T. Cuttino
 8:00—Round-Table Discussion

FOUNDER'S DAY

Thursday: November 6, 1952

A. M.

- 8:30—Registration
 9:00—Possible Carcinogenic Effect of Smegma on the Uterine Cervix... Dr. H. R. Pratt-Thomas
 9:45—The Polyneuritides, with Emphasis on Pathology Dr. Webb Haymaker
 10:30—The American Physician in Army Medicine—Past & Future Dr. J. Q. Simmons
 11:15—Backache in Medical Practice Dr. P. R. Lipscomb
 12:00—Renal Disease in Childhood and its Management Dr. M. I. Rubin
 1:00—Medical College Luncheon
 2:30—Diseases of the Vulva & Vagina Dr. L. A. Wilson, Jr.
 3:15—Brucellosis and "Rheumatic" Heart Disease Dr. Tom Peery
 4:00—Dedication of New Laboratory Building — Spaker: Dr. Charles L. Dunham
 7:30—Founder's Day Banquet — Presentation: Dr. Jack C. Norris

POSTGRADUATE SEMINAR (continued)

Friday: November 7, 1952

- 9:00—Diagnosis & Treatment of Cystic Mastitis Drs. John C. Hawk & J. T. Cuttino
 10:00—Surgery for the Ambulatory Patient Dr. H. W. Mayo, Jr.
 11:00—Surgery in the Aged Dr. F. E. Kredel
 12:00—Treatment of Burns Dr. W. H. Prioleau
 2:00—Treatment of Antepartum & Postpartum Hemorrhage Dr. A. L. Rivers
 3:00—Management of Apparent Sterility in the Female Dr. T. G. Herbert
 4:00—Office Gynecology Dr. James M. Wilson
 5:00—Indications for Hysterectomy Dr. L. L. Hester

Barnes Auditorium—Charleston, S. C.

The Journal of the South Carolina Medical Association

EDITOR: Julian P. Price

Florence, S. C.

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Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

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OCTOBER, 1952

ELECTION DAY

Ours is not a political organization nor is this Journal a political publication, but we cannot but comment upon the situation which exists in South Carolina.

As this is being written, both candidates for the Presidency have declared their intention of visiting South Carolina and of speaking to the people of the state in Columbia. Such a condition of affairs is truly remarkable since it is the first time in history that such has occurred. It gives those of us in this state a feeling of wonder and of pride.

For so these many years we, along with most of the other southern states, have been the forgotten areas during presidential elections. Our votes were so taken for granted that no one paid any attention to us. Now suddenly, the idea has suddenly dawned upon both national parties that South Carolinians do vote—and strenuous effort is being made to have us vote in this or that way. Wonders never cease.

What will be the outcome? Will the old Palmetto State stand pat and register its vote in the Democratic column as it has for many decades or will it cast tradition aside and cast its vote for the Republican candidates? Will the present upsurge of feeling result in the formation of two strong parties in the state—which is sorely needed—or will it be but a flash in the pan? Will this year be the one year in which both national political parties pay us attention, or will it be the beginning of many such election years? Being neither a prophet nor the son of a prophet, we will attempt no answers to these questions. But we will follow with great interest the doings of the weeks ahead and we will be sitting up late at night after all the votes have been cast on Election Day to hear the results. And above all, we will vote our own convictions on Election Day itself, truly thankful that this is still a country in which one is his own master in the voting booth.

KEOGH - REED BILLS

Of vital concern to all professional men and to those business men who are self-employed are the Keogh-Reed Bill which were introduced in the last session of Congress. Following hearings on these bills in May, 1952, certain changes were made following suggestions made by the American Bar Association, American Medical Association and others. These bills will be introduced in the next Congress and it would be wise for all physicians to become acquainted with their content and to discuss them with their Senators and Congressmen.

The principles of the original bills remain unchanged—to permit self-employed taxpayers and employed taxpayers not now covered by pension plans to defer taxes on certain portions of their current income, invested to secure retirement benefits. The general limitations on tax deferment to be—not more than 10% of earned income, or \$7,500 annually, whichever is less. The changes which appear in the revised bills are: (a) a provision which gives tax deferment, not only on investments made in a restricted retirement plan, but also for investment made by the purchase by an individual directly from an insurance company of a restricted annuity plan, (b) an over-all lifetime income limitation of \$150,000 which may be excluded by one person from gross income, (c) a provision to permit eligible taxpayers now over 55 years of age to exclude more than 10% of their earned income during the period of 1953 to 1972, (d) a provision which allows for a carry-over period of not more than five years, this to assist taxpayers who have extreme fluctuation in income, (e) setting the age at which saving funds may be withdrawn at 65 except in the case of infirmity or total disability.

In discussing these bills, the special committee on retirement benefits of the American Bar Association has this to say: "It cannot be emphasized too often that the proposed legislation is not social welfare legislation for those who are unable to provide for themselves. On the contrary, it is legislation to help

the independent, old-fashioned American who wants to take care of himself, and who wants to be in a position to help take care of the weak and unfortunate whether they are dependent upon him or not. In furnishing these sturdy, self-supporting taxpayers the opportunity to do so, the Keogh-Reed bills strike a refreshing new note in both the law and economics relating to retirement benefits."

We can but say Amen to the sentiments expressed and voice the hope that all of the members of our Association will support these bills when they appear in Congress.

DIABETES DETECTION WEEK

The American Diabetes Association will launch its fifth nationwide Diabetes Detection Drive during the week of November 16-22. This drive is unique in that it is a non-fund raising, educational and case-finding program which is channeled exclusively through the medical profession.

There has been a rapid growth in the number of medical societies which have joined in this national effort. To date, thirty state and nearly seven hundred county medical societies have indicated their intention of participating in the 1952 program. Six county medical societies in South Carolina are making plans to join in the effort.

It is our belief that the public will not only be benefited by this program through the finding of patients with diabetes, but that they will also be taught another lesson in the value of preventive medicine. We also feel that this effort should receive the support of all practicing physicians since it affords the public an excellent example of what doctors are ready to do in the field of education and good public relations.

NEWS FROM A. M. A.

CLINICAL SESSION GEARED FOR GP

The sixth annual Clinical Session of the American Medical Association—meeting December 2-5 in Denver—will feature practical demonstrations on various phases of medicine of special educational value to the general practitioner. More than 60 scientific exhibits will provide the GP with a postgraduate course in such subjects as office anesthesia, cardiology, dermatology, endocrinology, gynecology, laboratory procedures, otolaryngology, pediatrics and proctology. Emphasis will be on diagnosis and treatment.

In addition to scientific papers presented by leading physicians from all over the United States, highlights of the meeting will include a large technical exhibit, surgical and clinical demonstrations on color television and motion pictures. All technical and scientific exhibits and scientific sessions will be held at Denver's recently-enlarged Municipal Auditorium.

INDUSTRIAL HEALTH PROGRAM FOR THE GP

A program to interest general practitioners in industrial medicine recently was launched by the joint committee on education of the American Academy of General Practice and the Council on Industrial Health

of the American Medical Association. The project proposes to encourage an understanding of industrial health problems by management and physicians and to develop an education program geared to the GP on both the undergraduate and postgraduate level.

Since more than 90 per cent of American industries employ less than 100 workers, the "family doctor" also must be educated on the part he can play in supervising and directing health and safety programs in small plants without interfering with his regular practice. The AMA's Council is prepared to assist local medical societies in carrying out educational programs designed to bring the employer and physician together by sponsoring local industrial health meetings.

INDUSTRIAL FIRMS PURCHASE "TODAY'S HEALTH" FOR EMPLOYEES

Large bulk orders of "Today's Health" magazine from several American industrial firms have been reported by the "Today's Health" Circulation Department as a result of continued promotion to industrial physicians. The Timken Roller Bearing Company of Canton, Ohio, for example, currently provides copies of "Today's Health" for the more than 1,300 supervisory personnel throughout its organization. The Chesapeake and Potomac Telephone Companies of Washington, D. C., have purchased about 250 subscriptions for chief operators in the Virginia, Maryland, West Virginia and District of Columbia area.

This year, the Pepsi-Cola Company is supplying "Today's Health" to a dozen of its locally-owned branch offices on a trial basis. If successful, the company will encourage all of its branch offices to subscribe for employees. Many firms are ordering from six to twelve copies for employee reading rooms.

SAMA HONORARY MEMBERSHIPS OPEN TO PHYSICIANS

"Keep up with the young men who are keeping up with you" is the theme of a fall campaign now under way by the Student American Medical Association to encourage physicians to join the organization as honorary members. This new membership category was created at the request of doctors who wish to keep in touch with the student side of medical education, reports David Buchanan, national president.

Honorary membership, with yearly dues of five dollars, entitles the physician to a subscription to the monthly 72-page Journal of the SAMA as well as participation in the annual convention and other activities of the association. Physicians and friends of the medical student interested in becoming honorary members should contact Mr. David Buchanan, Student American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

AMA PREPARES NEW HEALTH EXHIBIT

Designed for lay audiences, a new portable exhibit entitled "Health—1952" will be available by mid-September from the AMA's Bureau of Exhibits for state and county medical societies. The exhibit presents an over-all picture of health conditions in the United States at the present time. The first panel, containing a large, colored modern adaptation of Sir Luke Fildes' painting, "The Doctor," emphasizes improved health conditions in the country today—showing that life expectancy has increased, tuberculosis, diphtheria and pneumonia deaths have skidded to an all-time low, mothers and babies have a much greater chance of surviving today. The second theme shows that Americans require less working time to pay for

medical care today as compared with 15 years ago. Finally, the exhibit points out that today there is an easier way to pay for medical care—through voluntary health insurance.

The Bureau plans to revise and bring the exhibit up to date each year. The only cost involved to medical societies will be the shipping charges both ways.

DOCTORS URGED TO SEND IN POISONING REPORTS

The Committee on Pesticides of the American Medical Association currently is undertaking a country-wide toxicological study of cases of poisoning resulting from the use of insecticides, rodenticides, fungicides, weed killers, fumigants, repellents and related types of chemicals used in agriculture and the home. This information will be used to expand its permanent file of such cases for use by physicians and allied medical personnel.

Since much of the Committee's information on pesticide poisoning has been compiled from unpublished isolated cases which were brought to its attention, the Committee appeals to physicians to submit records on cases of non-fatal and fatal poisonings from pesticides. The Committee points out that summary data on the pertinent facts of the poisonings and the circumstances of their occurrence would be sufficient in most instances. The Committee is functioning as a center for reporting this type of poisoning cases.

NEWS ITEMS

VA COURSE IN PSYCHIATRY AND NEUROLOGY

The Veterans Administration is instituting a four-month intensive training course in psychiatry and neurology to fit the needs of physicians without such previous training who are assigned to duty in 22 predominantly psychiatric hospitals. Physicians who have been engaged in general practice may request this training upon applying for a position at one of these hospitals.

The course will be held at the VA Hospitals in Coatesville, Pennsylvania; Palo Alto, California; and a joint Downey-Hines, Illinois, program near Chicago, Illinois. Physicians will be employed at salaries commensurate with their training and experience (salary range: \$5,500 to \$11,800 per annum) and assigned to the course with travel and per diem for the four-month period.

Information and applications may be obtained from your nearest VA Hospital or Regional Office, or by writing to the Chief Medical Director, Veterans Administration Central Office, Washington 25, D. C.

Dr. A. J. Goforth has returned to Greenville after completing a tour of duty with the army in Japan. He is associated with Dr. J. W. Jervey.

Dr. Robert E. Livingston who has been practicing medicine in Newberry for a number of years has gone to New York where he will specialize in eye, ear, nose and throat work.

Dr. Joseph Dillard is associated with Dr. J. William Pitts of Columbia, in the practice of medicine.

Dr. Reginald E. Gregory is a new general practitioner in Greenville.

Dr. A. Heide Davis has reopened his offices in Greenville for the practice of general medicine. He has recently returned from a two year tour of duty with the Navy.

Dr. C. L. Mathis, Jr. who has been serving as health officer for Horry and Georgetown Counties, with residence in Georgetown, has been transferred to Conway. He will be a full time health officer for Horry County.

Dr. P. M. Temples, formerly of Spartanburg, has moved to Columbia where he has accepted a position with the South Carolina Tuberculosis Hospital at State Park.

Dr. Frances Ingell Doyle has recently opened offices in Georgetown where her practice will be limited to pediatrics.

Dr. Hasell G. Ross is now associated with Dr. Emmett Madden, Columbia, in the practice of internal medicine.

Dr. Luther C. Martin announces the opening of his office for the practice of neurological surgery, Charleston.

Dr. L. Crowl is now associated with Dr. J. E. Crossland, Greenville, in the general practice of medicine.

Dr. Louis D. Hayman has opened offices in Mullins for the practice of internal medicine.

Drs. Young and Perry of Anderson announce the association of Dr. James H. Young in the practice of general surgery.

Dr. Joel T. Wyman has returned to Anderson after three years of special study in dermatology. He has opened offices there and will limit his practice to dermatology.

Dr. Charles F. Timmons is now associated with his brother Dr. Thad A. Timmons of Lake City, in the practice of medicine.

Dr. Charles R. Holmes has returned to his home town, Columbia, and opened offices for the practice of internal medicine.

A.S.T.A. OFFERS COMPLIMENTARY COPIES OF GUIDE FOR PLANNING PHYSICIANS' OFFICES

The American Surgical Trade Association, with the cooperation of the United States Public Health Service, has published a guide to assist physicians in planning their offices. Any physician desiring a complimentary copy may obtain it by writing to Homer G. Klene, Secretary, American Surgical Trade Association, 176 West Adams St., Chicago 2, Ill.

Prepared under the general direction of Dr. John W. Cronin, Chief of the Division of Hospital Facilities of the United States Public Health Service, the guide was issued following an extensive study. Suggestions were made by the American Medical Association, the Medical Society of the District of Columbia, architects and specialists of the United States Public Health Service, and manufacturers and distributors of surgical and medical equipment.

"The Guide for Planning Physicians' Offices" is in the form of a 32-page brochure containing typical layouts for the various specialties such as: general practice, obstetrics and gynecology, pediatrics, surgery, otorhinolaryngology, orthopedics, ophthalmology, dermatology, pathology, radiology, psychiatry, urology and proctology. The Guide also contains suggestions as to how offices can best be arranged for maximum comfort and efficiency. A key chart helps to identify and locate each piece of furniture and equipment in scale drawings.

"Urology Award"—The American Urological Association offers an annual award of \$1000.00 (first prize of \$500.00, second prize \$300.00 and third prize \$200.00) for essays on the result of some clinical or laboratory research in Urology. Competition shall be limited to urologists who have been in such specific practice for not more than five years and to men in training to become urologists.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Hotel Jefferson, St. Louis, Missouri, May 11-14, 1953.

For full particulars write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before January 15, 1953."

CORRESPONDENCE

FEDERAL SECURITY AGENCY

Food and Drug Administration
Washington 25, D. C.

September 8, 1952

Journal
South Carolina Medical Association
Florence, South Carolina
Dear Sir:

You may be interested in the enclosed opinion of the U. S. Court of Appeals for the Fifth Circuit in the case of *U. S. v. Hoxsey Cancer Clinic, a Partnership, and Harry M. Hoxsey, an Individual*. This opinion is the result of an appeal in a vigorously contested case tried in the U. S. District Court at Dallas, Texas. It reverses the judgment of the trial Judge (William H. Atwell, N. Dist. of Texas) and directs that Court to issue an injunction prohibiting the defendants from distributing in interstate commerce brownish-black, and pink, liquids intended for the treatment of cancer in man.

In many parts of the country, people are taking the Hoxsey medicines in the belief that they may be an effective treatment for cancer. Friends and relatives of cancer victims frequently query local physicians concerning this treatment. You may wish to publish information about this case so that physicians will have the facts at hand concerning these drugs, in the event of such inquiries.

The following important principles are laid down in the Circuit Court opinion, based on testimony by cancer experts.

1. "°°°there is only one reliable and accurate means of determining whether what is thought to be cancer is, in truth and fact, actually cancer. This requires a biopsy, a microscopic examination of a piece of tissue removed from the infected and diseased region."
2. "°°°the opinion of a layman as to whether he has, or had, cancer, or a like opinion as to whether he has been cured and no longer bears the disease, if, in fact, it ever actually existed, is entitled to little, if any, weight."
3. "°°°despite the vast and continuous research which has been conducted into the cause of, and possible cure for, cancer the aggregate of medical experience and qualified experts recognize in the treatment of internal cancer only the methods of surgery, X-ray, radium and some of the radioactive by-products of atomic bomb production."
4. "°°°Upon such subjects a Court should not be so blind and deaf as to fail to see, hear and understand the import and effect of such matters of general public knowledge and acceptance, especially where they are established by the overwhelming weight of disinterested testimony°°°."

The Hoxsey Clinic is located in Dallas, Texas, and ships its drugs to patients in many other States. According to the unanimous opinion of the Court of Appeals, consisting of Judges Russel, Hutcheson, and Rives, "the overwhelming weight of the credible evidence requires a conclusion that the representation that the Hoxsey liquid medicines are efficacious in the cure of cancer is °°° false and misleading. The evidence as a whole does not support the finding of the trial Court that 'some it cures, and some it does not cure, and some it relieves somewhat'."

Under the law the defendants still have the right to petition for review by the U. S. Supreme Court.

Background information on the Hoxsey Clinic is given in the attached report prepared by the Division of Medicine of the Food and Drug Administration.

Very truly yours,

C. W. Crawford

Commissioner of Food and Drugs

DEATHS

EDGAR O. HORGER

Dr. Edgar O. Horger, 75, died on September 17, following a short illness.

A native of Orangeburg County, Dr. Horger was graduated from the Medical College of South Carolina in 1901. Shortly thereafter he entered general practice in Eutawville where he practiced until his retirement several years ago.

Dr. Horger is survived by his widow, the former



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JOHN T. HOWELL

The body of Dr. John T. Howell, 74, who had been missing since September 9, was found on September 17 in his car near Florence.

Dr. Howell was born in Keuly, North Carolina, and received his education at the University of North Carolina and the University of Maryland (Class of 1911). He had practiced in Florence for the past thirty-four years.

Surviving Dr. Howell is his widow, the former Miss Reba Anderson.

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SOUTHERN MEDICAL AUXILIARY INVITES WIVES TO MIAMI

The Southern Medical Association meets in Miami, Fla., Nov. 10-13, 1952, and all indications are that it will be a meeting to be long remembered . . . The hospitable Miamians are going all out in planning a delightful social program for the ladies . . .

A (tentative) Auxiliary program is as follows:

SUNDAY, NOV. 9

Special Executive Committee meetings

MONDAY, NOV. 10

Luncheon for Past Presidents

Luncheon for Councilors

TUESDAY, NOV. 11

Executive Board Breakfast

General Sessions

Doctors Day Luncheon

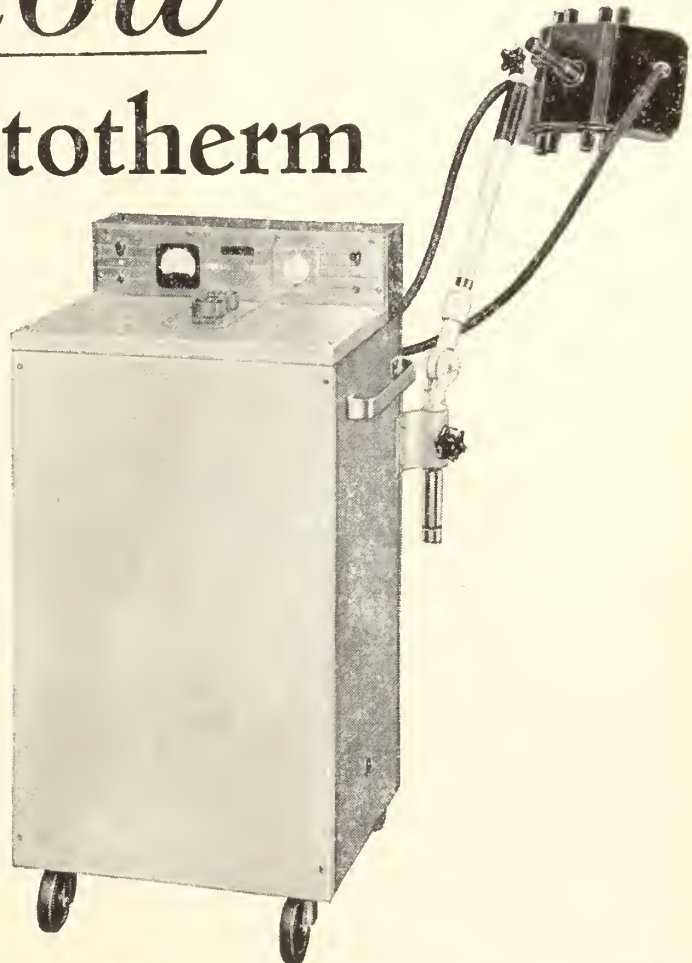
Other Social Activities, including a Fish Fry on the beach.

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GREENVILLE — F. F. Chisholm, 204 Cureton St.

WEDNESDAY, NOV. 12

General Sessions

Luncheon honoring the President, Mrs. V. Eugene Holcombe, the President-Elect, Mrs. Richard Stover, visiting State Presidents and Charter Members

THURSDAY, NOV. 13

Executive Board Banquet

The Auxiliary to the American Medical Association

will furnish two of the speakers. Mrs. Ralph B. Eusden, President of the Auxiliary to the A. M. A., will discuss the aims and general program of the Auxiliary, and Mrs. John McCuskey, a vice Chairman, will speak on nurse recruitment.

Wives attending the Southern Medical Association meeting with their husbands are cordially invited to attend all activities of the Auxiliary.

All reservations for luncheons should be made early.

THE TEN POINT PROGRAM

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

THE NEXT TWENTY YEARS IN MEDICINE

If modern medicine is to deal with man as a whole, teaching and research centers must learn to coordinate their activities toward this goal

LESTER J. EVANS*

All evidence points to the fact that medicine is now in a period of critical growth. I use the word "medicine" to include that wide spectrum of knowledge, professional skills, technologies and physical facilities which in this modern day can be brought to bear in the care of the sick and the prevention of illness.

This period of critical growth, which is still in its early stages, is not yet clearly enough defined to be seen in all its proportions, but I believe that in social and scientific significance it will prove to be as profound as that period stretching roughly from 1890 to 1910 which can now be viewed quite clearly in the perspectives of history. Medicine as it was then known was coming to be viewed against the backdrop of the natural sciences, biology, chemistry and physics.

What has happened in the first part of this half-century followed quite naturally on what was taking shape in the latter part of the previous century. Imaginative and inquisitive physicians, teachers and scientists were delving into the intricacies of certain disease phenomena by the application of knowledge from the sciences; such workers continue to reveal the nature of biological, physiological and disease processes which were not even thought of 50 or 75 years ago.

But, with the intense concentration on the solution of urgent and complex problems found in the hospital ward and laboratory, it is only recently that we have begun to seek additional areas of knowledge which might be drawn upon to understand more fully human health as well as illness. This looking about is one of

the characteristics of the present period of medical development—imaginative and inquisitive people are now at work across a broader front.

Among the new areas to which they are turning are the social and behavioral sciences. It is from them that more will be learned about the nature and needs of man both as an individual and in relation to other men as they collectively make up society.

The logical question which now arises is what does all this mean for the future of medicine? Is it possible that the concepts and practices of the past may be altered through this more complete understanding of man? When he is viewed as a whole it becomes clear that no part or function of him acts independently of any other part or function—he is really a total individual and acts as such.

The very means by which progress has been made, however, is now a threat to the fulfillment of the potentially of dealing with man as a whole. Medicine has become fragmented and segmented. The special areas of research and practice have become so complex and involved that the relationship between them is tenuous in many instances. If medicine is to deal with man as a whole, then teaching and research centers must find the ways and means of bringing about an integration and coordination of activities in the interests of this whole person. And this integration must be brought about without destroying the excellence of anything we now have.

I have long wanted an opportunity to explore with an interested group what is involved in this reintegration of medicine. About a year ago the board of governors of the Society of the New York Hospital, the medical board of the hospital and the faculty of Cornell University Medical College decided to tackle this problem through the ambulant person or outpatient in the general medical clinic. The idea is always to keep the patient sharply in view in order that the services rendered to him can be made available to him day in and day out, whether ill or well. It also is intended that he be dealt with as a member of a family group and, further, with the full recognition that his family is a

*Dr. Evans is executive associate of the Commonwealth Fund, New York City. This article is adapted from his address at the Charter Day Exercises of the Society of the New York Hospital, May 1952.



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part of this community. What is hoped for in this program is included in the term "comprehensive medicine."

The achievement of this kind of service will not be as simple as it might seem when we look at the size of this and other centers, or when we think how specialized medical practice has become. Even more obviously we have come to focus our attention on the bedpatient, looking only incidentally on the ambulant patient, either as he is ready to come into the hospital or to leave it.

The demonstration and practice of comprehensive medicine, it seems to me, calls for principal attention to this ambulant patient because he is society and he is walking into and out of this institution daily by the hundreds. He brings his environment with him. He does have a family. He is concerned with the day-to-day problems of living, and his illness is a part of his very existence.

Outpatient facilities, because they have been developed along the pattern of the inpatient services—the clinics even having the same names: medicine, surgery, pediatrics, gynecology, ophthalmology, neurology and so on—make it difficult for us to view this patient as a total person. Little can be accomplished in the practice of comprehensive medicine if we continue to look at only parts of the patient and those parts on separate floors and wings of the building without some means of bringing about a natural and smoothly functioning coordination.

I wish to suggest a second focal point around which the activities of an institution such as this are centered. I have already mentioned the patient; now I mention the student. As you proceed in the development of a comprehensive medical service around these two focal points, I believe that you will find the clue to it in continuity—continuity of service to the patient, continuity of observation and study and continuity of relationship between the patient, his physicians, the student and other health workers.

There is another aspect of comprehensive medicine, completeness of service, which I shall pass over here because time is limited and you already possess many of the necessary components.

Continuity of service will call for an administrative mechanism which bridges the functions of the inpatient and outpatient activities and will include those in the home and in the community. A natural sequency will be the pulling together of the activities of many separate clinical departments and specialties. In time one may cease to speak of referring the patient from this department to that, but rather to think of the services coming to the patient. The patient should come to feel more at ease as his needs are met in a satisfying manner. A further element of continuity of service is that members of the various professional groups who deal with patients will increasingly work

together so that the job done by one blends smoothly into that done by another.

If continuity of service can be achieved, then the way is opened for continuity of observation and study. I believe that generally we are not yet prepared to appreciate all that may be learned by following patients and well people through either portions or the whole of their life spans. Obviously the natural histories of many illnesses will be more completely revealed. We will come to look upon illness in different terms than we do now as we observe the psychological, biological and social processes of adaptation and adjustment between a person and his environment. Then we will have extended opportunity to learn about normal behavior and function. What is health when not defined as absence of disease? What are the inherent characteristics of individuals which seem to make them susceptible or immune to certain kinds of diseases or states of ill health?

Further, and I should like to emphasize this, there will open up a completely new area for research in medical care. True, many have been intimately concerned with medical care, but what we know is segmental in nature—a bit here and a bit there. Many questions must be answered: What is involved in complete or comprehensive medical care? Who gives it? Who pays for it? What are the relative tasks of the several professional groups involved in complete service to the patient? This field of research can be tackled only when an institution such as this one commits itself to service and study on a group of patients who will be followed indefinitely.

Finally, I come to education. Education will continue to be a primary responsibility of the medical center. If the practice of medicine is based upon a relationship between two people, one asking help of the other as well as the application of a large variety of technical procedures, then future practitioners must have an opportunity during their student days to learn by experience what this means. We can look on this clinic for comprehensive medicine as providing the setting for one of the very exciting experiments of the moment in medical education only if this fact is recognized.

In order to give the student full opportunity to experience the meaning of this continuing relationship between himself and the patient, the senior year clerkship at Cornell has been rearranged. Instead of a series of blocks of time devoted to special services, one-half of the year now will be devoted to a continuous clerkship in which several of the major departments will cooperate. During this time the students will take care of the same patients, following them from the home into the clinic and hospital and back as there is need. The teachers will be from several special fields, all working together except as there is need for certain specialized teaching. The student thus should gain greater understanding of the

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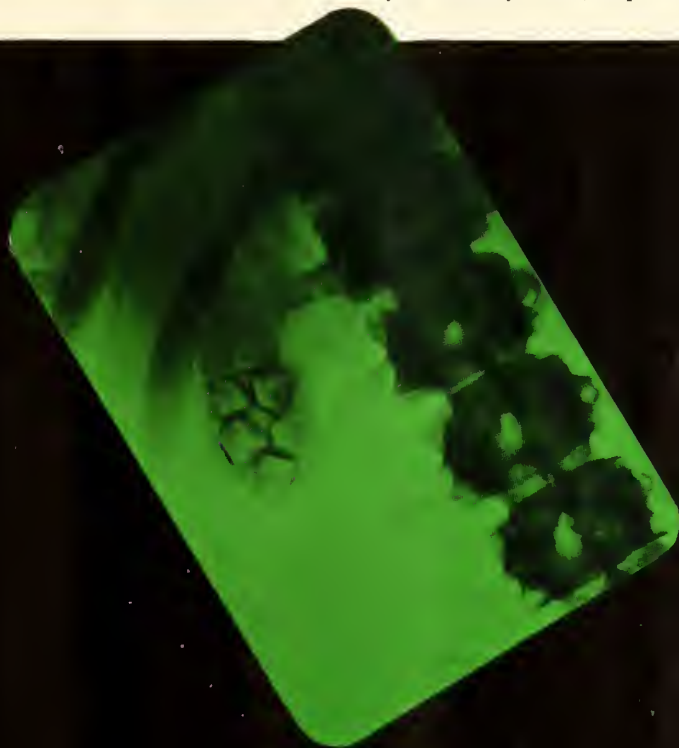
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way in which he can bring the knowledge and skills from the several fields of medicine to bear upon the problems presented by his patients.

Now I want to say just a word about the opportunities and the evolving responsibility for providing graduate training in these broader concepts of medical service. This year three of your younger staff members have gone from this institution to other universities where they will have an opportunity to apply some of the concepts of comprehensive medicine in different settings. One has just accepted the deanship of a medical school in New England, another is actively engaged in the reorganization of the entire outpatient service of a publicly-supported hospital in a Western city where it is hoped to provide continuing service to patients, a third is going to the full-time professorship of medicine in a midwestern medical school and already has stated as his objective the practice and teaching of comprehensive medicine.

I think I have answered the question: What does the practice of comprehensive medicine mean for the future of this institution and for the future of medicine in this community? As regards this institution, it will enable you to fulfill the goals of service, education and leadership. For the future of medicine in this community you will have an opportunity to demonstrate, practice and teach medicine which has its roots in the lives and needs of the people.

HEALTH PLANS GAIN WIDELY IN NATION

More persons in this country were protected through voluntary plans against sickness and accident in 1951 than ever before, according to the results of a survey released by the Health Insurance Council of the Institute of Life Insurance in its annual report on accident and health coverage in the United States.

After allowing for duplication of coverage, there were 85,991,000 persons with protection against hospital expense when 1951 ended, an increase of 12 per cent over the 76,961,000 persons covered a year earlier. Compared with ten years earlier, coverage had increased nearly 70,000,000 persons. This type of protection, the council explained, provides benefits toward payment of hospital charges for room, board and many miscellaneous services.

Surgical expense protection covered 65,535,000 persons at the close of last year. This was an increase of 20 per cent over the 1950 year-end total of 54,477,000. In 1941, fewer than 7,000,000 persons were estimated to have had such protection, which provides for the payment of benefits in the event of surgical operations.

The newest form in the voluntary health field is medical expense protection, which was extended to 27,723,000 persons at the end of 1951, compared with 21,589,000 at the end of 1950, an increase of 28 per

cent. Only 3,000,000 persons were covered against medical expenses ten years ago, it was estimated.

Voluntary protection against loss of income resulting from disability, is the oldest form of voluntary health insurance in the United States, covered 39,702,000 subscribers at the close of 1951, an increase of 6 per cent over the 1950 total of 37,293,000 persons. Known commonly as weekly indemnity insurance, this type protects almost two-thirds of America's breadwinners against loss of income if injury or illness prevent them from working temporarily.

Organizations covered in the survey included insurance companies, Blue Cross, Blue Shield, local medical societies and other independent plans adopted by industry, employee benefit associations and private clinics.

PRESCRIPTION LAW REQUIREMENTS EXPLAINED*

The words, "Caution: Federal law prohibits dispensing without a prescription," while directed to pharmacists, are now, more than ever, vitally important to the physician as well.

The Durham-Humphrey Act, governing the refilling of certain prescriptions, became effective on April 26, 1952. The importance of cooperation between physicians and pharmacists in making the letter of this law entirely effective cannot be overemphasized. The protection of the public is foremost, and compliance with the law in all respects is essential.

In general, the law now provides that whenever a drug or medicine carries the above words, the pharmacist must have the prescribing physician's authorization before it can be refilled. The doctor may delegate this authority to an employee for a prescription refill, or he may state on each prescription the number of times he wishes to have it refilled.

The letter of the law provides that such drugs or medicines carrying that inscription be dispensed only on:

1. A written prescription giving the date, name and address of the patient, item and quantity of drug prescribed, directions for use, and the legal signature of the prescriber.
2. A telephoned order directly to the pharmacist by the physician or by an authorized employee, giving the same information as specified above in (1).
3. Refills are permitted only when authorized orally or in writing by the physician or by an authorized employee. Physicians may also authorize refills by indicating on the original prescription the number of times the prescription may be refilled.

A majority of prescriptions written today carry this

*Reprinted from MINNESOTA MEDICINE, August, 1952.

legend, and include such drugs and medicines as antibiotics, sulfa drugs, thyroid, benzedrine, dexedrine, amphetamines, stilbestrols, estrogens, and antihistamines.

All prescriptions for or containing barbitol and any derivative must be written in ink or typewritten, contain the name and address of the person for whose use it is intended, must state the item and quantity of the drug, full directions for use, the date, and signature of the prescriber. No barbiturate prescriptions can be refilled except with the written or verbal consent of the prescriber.

All prescriptions for narcotics must be in writing only; no oral or phone prescriptions are permitted. Prescriptions cannot be refilled. Prescriptions must contain the patient's name and address, item and quantity of drug prescribed, the prescriber's name, address, registration number and signature. The only exception to this is any codeine preparation containing not more than one gr. of codeine per ounce.

The Federal Bureau of Narcotics regulation on narcotics says:

"The furnishing of narcotics to telephone advice of practitioners is prohibited, whether prescriptions covering such orders are subsequently received or not, except that in an emergency a druggist may deliver narcotics through his employee or responsible agent pursuant to a telephone order, provided the employee or agent is supplied with a properly prepared prescription before delivery is made, which prescription shall be turned over to the druggist and filed by him as required by law."

Under the Durham-Humphrey act, the pharmacist is legally bound to observe all of its provisions. This, naturally, will entail many additional phone calls to doctors' offices. This extra burden on the doctor is a necessary one. In aiding the pharmacist to comply with the law, it is vital that physicians cooperate fully with them. Less trouble and confusion will result, as well as the realization of the important part played in protecting the public against the flagrant and indiscriminate use of the drug and medicine prescription and its refilling.

Outlining four major objections to any Federal compulsory health insurance proposal, a recent survey in the *Quarterly Journal of Economics* at Harvard University listed those drawbacks to be:

- "1. The government should not compel people to spend money on any particular service unless that service cannot be obtained in any other way or unless the government can provide the service more efficiently than private enterprise.
- "2. Costs are too high.
- "3. The quality of medical care deteriorates under a compulsory insurance scheme.
- "4. Doctors will not accept it."

Regarding the first point, the authors, economists Rita Ricardo Campbell and W. Glen Campbell, state that at present those who want health insurance can buy it as they buy any other goods or service. Voluntary health insurance plans are available to the average citizen at a cost no greater than what it would be under a compulsory, government-run system. The survey notes that Dr. Dean A. Clark, in his research report to the Senate subcommittee on health, estimated that "75 million persons were protected in full or in part by voluntary insurance against the costs of medical and hospital care. There can be no question of the fact that the voluntary insurance plans are expanding in areas where there is a demand and a need for them, it is added."

On the second point, involving costs of a compulsory plan, the article points out that the experiences of all countries which have adopted this form of health insurance show that the costs of medical care increase greatly. Quoting several estimates, the authors observe, "It would be interesting to know how large a percentage of the population would favor compulsory health insurance if they were told it would cost them a payroll deduction of from 6 to 8 per cent."

A drop in the present high quality of medical care would be part of the proposed compulsory health insurance scheme. The study indicates that the great increase in demand for medical attention strains existing personnel and facilities and leads to some deterioration in services rendered. The report states: "Doctors' offices become crowded with patients who are forced to wait, often many hours to be examined. The time and thoroughness devoted to each case must be reduced."

The total number of physicians in the United States has reached an all-time high of 211,680 as of the end of 1951. The annual licensure report of the American Medical Association notes that this represented a net increase of 2,640 doctors during 1951.

In 1951 there were 6,282 persons who for the first time, obtained licenses to practice in the United States. The net gain of 2,640 for the year was after an estimate of the number of deaths of physicians based on reports to the American Medical Association.

The report showed that New York had the greatest number of first-time licentiates with 743; California was second with 526. Next in order were Illinois, 437; Ohio, 394; and Pennsylvania, 388. Increases in the number of first-time licentiates, as compared with 1950 figures, occurred in 26 states.

The report reveals the general trend in locations of doctors throughout the nation. California issued the greatest number of licenses, 1,367. The report states: "Of these, 844 represented licensures by reciprocity or endorsement of credentials, including 216 candidates who held certificates of the National Board of Medical Examiners. Illinois provided California with the largest

number of doctors under state reciprocal licenses, 95; Minnesota was second with 53. California state board examinations resulted in 523 licenses."

The report indicated the high medical training rating of the medical schools of the United States, all seventy-two of which are now approved by the American Medical Association's Council on Medical Education and Hospitals. Of 5,018 graduates of existing United States schools who last year took written examinations for licenses, 4,874, or 97.1 per cent passed. Rates for other schools were considerably lower. Other schools include Canadian schools, extinct approved schools, foreign schools, unapproved schools and schools of osteopathy. Altogether, 6,473 persons took state board examinations: 5,716, or 88.3 per cent, received passing grades.

This notable increase in total number of physicians in the United States could hardly be a better answer to those who still advocate government-controlled medicine. Their arguments have been based on the contention that there has been and still is a tragic doctor shortage in America. Concrete action and constant improvement over the years has come largely from the efforts of the medical profession itself. With this larger figure comes assurance to Americans that medical care and service will be even better in the future than the high quality of the past and present.

PROFESSIONS SHOW RISE IN EARNINGS

Physicians First With Average Income of \$12,518 Last Year: The average physician last year earned \$12,518 or \$980 more than in 1950. The average lawyer made \$9,375, or \$303 more than in 1950, and the average dentist, \$7,743, or \$450 more.

These figures, made public today by the Office of Business Economics of the Commerce Department, are based on recent mail surveys of the three professions. They are the average earnings, before taxes, of physicians, lawyers and dentists regardless of whether they were independent or salaried practitioners.

A breakdown of the figures showed, however, that as in the past, the independent physicians fared better than those on salary. The average net income of the independent physician in 1951 was \$13,378, while the salaried members of the profession made \$9,522. Of an estimated 175,000 physicians, about 38,500 are salaried.

It was the other way around with the legal profession, however, with the salaried lawyers earning on an average about \$10,197 and the independent ones making \$8,936. Salaried lawyers represent about 35 per cent, or 73,500 of an estimated 210,000 attorneys in the country.

While the report showed that the average independent dentist made \$7,856 last year, it said that there were too few returns from the salaried dentists to permit estimates. According to the Bureau of Census, the country has about 77,000 dentists.

The report noted that from 1949 to 1951, incomes of physicians (independent and salaried) rose 13 per cent, while dentists and lawyers reported increases of about 10 per cent.

THE HIGH COST OF HOSPITALIZED MEDICAL CARE*

All physicians are disturbed by the increasing costs of illness. As lay persons discuss this situation, there is an obvious tendency to designate these costs as "doctor bills," and the entire onus of these costs is attributed, willy-nilly, to the physician. The doctor is all too often inarticulate and the patient all too ready to believe that "somebody" has extracted an unreasonable profit from his individual illness.

In these troubled days of fifty-cent dollars, it is simple to explain a certain proportion of this increased cost; but what of this question: "Doctor, why does the hospital charge me \$2.50 for a fifty-cent shot of penicillin?"

The answer is as follows:

(1) The hospital is operated by a board of trustees, locally respectable and successful men *who serve without pay*.

(2) The trustees govern the activities of the hospital and its staff through an administrator, who carries out the wishes of the trustees and who receives a salary—not a commission or other indirect profit.

(3) A hospital is departmentalized. A large Iowa hospital has seventeen individual departments, all of which spend money. Of these seventeen departments, only six have any income. It is simple arithmetic to deduce that these six paying departments must carry the financial burden of eleven nonpaying departments.

(4) The hospital pharmacy is one of the profit-making departments. It must help carry the burden of the laundry, housekeeping, medical records, employees health service, etc. Hence, the apparent profit of \$2.00 is realized on the penicillin injection to cover these items.

(5) The apparent profit is far from real. It takes a total of twenty employee-minutes to prepare and administer an injection of penicillin. It requires equipment subject to breakage, loss, and deterioration. Possibly the hospital, not the pharmacy, may realize a profit of \$1.00 on this transaction.

*New York Times, July 23, 1952.

*Reprinted from Journal of Iowa State Medical Society, September, 1952.

(6) By the end of the month, when the other unprofitable hospital departments have used up this dollar, the administrator and trustees find the hospital is still operating at a loss.

(7) Very few hospitals "make a profit," and the usual loss is made up by charitable donations and bequests of public spirited citizens or businesses.

(8) Thus, the patient who felt that his hospital bill, stamped "Paid in Full," entitled him to complain about the \$2.50 drug charge was still the recipient of public charity. The hospital made no "profit" on him or his illness.

With the profit taken out of the patient's hospital stay, why then are the costs so great? A breakdown of the costs of the State of Wisconsin General Hospital has been reported by Dr. Erwin Schmidt. In 1935 the per diem cost (cost per bed per day) was \$4.55. In 1951, the per diem cost was \$15.22, an increase of 234 per cent. During this time, nursing service salaries increased by 434 per cent and other wages and salaries increased by 436 per cent. Thus, out of the \$10.67 per diem increase between 1935 and 1951, more than \$6.00 is directly attributable to increased wages and salaries. And yet the trained and accredited hospital nurses are not receiving more than plumbers' helpers. Perhaps the day will gradually dawn when:

- (1) Hospitals will bill the patients by cost accounting.
- (2) Highly trained nurses will not wander away into ancillary fields.
- (3) Routine nursing duties will be carried out by competent but less highly trained personnel.

The doctor owes it to his patient, as well as to himself, to seek an answer to these problems. Group decision can only follow individual thought.

U. S. STOCKHOLDERS PUT AT 6.5 MILLION*

About 6,500,000 individuals own publicly held stocks in this country, the Brookings Institution said today.

In a study entitled, "Share Ownership in the United States," the institution reported that the vast majority of the shareowners, or 76 per cent, earned less than \$10,000 a year after taxes. The survey also showed:

More men than women were stockholders.

Most persons bought stocks to make a profit.

Persons in the 50-59 age group owned more stocks than other age groups.

Share ownership was highest among administrative executives and college graduates.

The study said that one out of every sixteen persons in the adult population owned shares in at least one stock issue, and that there were one or more share owners in every tenth family. The 6, 500,000 stockholders are members of 4,750,000 family units.

There are 30,300,000 "shareholdings" in stock issues trades on organized stock exchanges and over-the-counter. Every individual holding counts as one shareholding. If a person owns a shares in five stocks he has five shareholdings, therefore, the number of shareholders is far less than the total of shareholdings. The number of shares in 16,655 stock issues classified as public-held is estimated at nearly 5,000,000,000.

WHY WOMEN OUTNUMBER MEN*

In 1950, for the first time in our history, the census has shown more females than males in our population. At that time there were about 1,430,000 more women than men, and the indications are that this excess will become even larger in the future.

Many factors are contributing to the growing predominance of females over males. Of these, the most important is the higher death rate of the males. At birth, the ratio of the two sexes has been very stable from year to year, at a level of about 1,055 males per 1,000 females. On the other hand, the ratio of male to female deaths has been increasing; in 1930 this ratio was 1.210 males per 1,000 females, and by 1951 it had risen to 1.333 males per 1,000 females.

Both sexes have shown a long-term improvement in morality, but the reduction has been more rapid among the females. As a result, the gain in population by natural increase (the excess of births over deaths) has been greater for females than for males. In the six postwar years, 1946 through 1951, for example, natural increase added nearly 7,000,000 females to the population of our country, exceeding the male increment by about 590,000.

Accentuating this trend has been the sex pattern of migration into and out of the United States. For most of the country's history, there was a marked excess of males over females among immigrants. However, the picture was reversed about 1930; in each year since then immigration has been predominately female. In fact, during the depression years 1932 to 1936, male immigrants were only two thirds as numerous as female immigrants. During the early postwar period the disparity was even greater. In one year—1946—for every male among our immigrants there were three females. This recent influx of women reflects, for the most part, the admission into our country of war brides and fiancées of American servicemen.

While fewer men than women have been coming into our country each year, more men than women

*New York Times, July 1, 1952.

*Reprinted from Statistical Bulletin, Metropolitan Life Insurance Company, August, 1952.

have been leaving. During the difficult years of the early 1930's, the number of male emigrants outnumbered females by almost 2 to 1. In no single year of that decade was this ratio less than $1\frac{1}{2}$ to 1. For most of the post war years, however, there has been a relatively small excess of males over females among our emigrants. In the five fiscal years ending June 30, 1950, somewhat over 13,000 more males than females left the country. On the other hand, during the same period there were 168,500 more females than males among our immigrants. There has thus been a net gain of 81,500 females over males by migration in the five years immediately after World War II.

War deaths have been another factor in widening

the margin between our male and female populations. The present excess of women over men would be about a third of a million less had it not been for our losses in World War II.

In view of these various trends, it is not surprising that, beginning with 1945, there has been a reversal of the sex ratio in our population. The excess of women is concentrated largely at ages 45 and over, where the sex ratio is 956 males per 1,000 females. This difference increases rapidly with advance in age, and at ages 70 and over it reaches 855 males over 1,000 females. According to present indications, the excess of females over males will grow, with an attendant increase in widowhood and dependency.

SUPPORT

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TEN POINT PROGRAM OF THE SOUTH CAROLINA MEDICAL ASSOCIATION

1. Cooperation

To promote closer cooperation and better understanding between all agencies, groups and individuals concerned with providing and improving medical care for the people of South Carolina.

2. Extension of Medical Care

To study constantly the need and availability of medical care in each county of the State and in the State at large.

To promote plans for providing or improving medical care where is a need, particularly in the rural areas.

3. Pre-Paid Hospital and Medical Care

To make voluntary pre-paid hospital and sickness insurance available to all the people of the State (through Blue Cross, Blue Shield, and commercial insurance policies), and to promote the widespread purchase of such insurance.

4. Care of Indigent

To work with local county and state agencies, and with philanthropic organizations, toward securing good medical care for the indigent.

5. Public Health

To support the South Carolina State Board of Health in its broad program of preventing diseases and of safeguarding the health of our people.

6. Health Councils

To support the State Health Council in its announced program. To sponsor

the formation of a County Health Council in every county of the state, and to encourage our members to support and to work with these organizations.

7. Hospitals

To promote the expansion of present hospital facilities and the building of new hospitals—where there is a definite need.

To strive for highest standards of professional care in the hospitals in the State.

8. Medical Colleges

To support the Medical College of the State of South Carolina and to bend our efforts toward keeping its standards of education on a par with other medical colleges throughout the country.

To promote good nursing education and good nursing care throughout the State.

9. Education of the Public

To acquaint the citizens of the State with regard to the problems of medical care in existence today, to inform them as to what is being done to solve these problems, and to advise with them as to further plans for securing better health and better medical care for the people of South Carolina.

10. Political Medicine

To prevent political control or domination of medical practice or of medical education.

A. M. A. NEWS

TV SHOWS TO HIGHLIGHT DENVER MEETING

Plans are being made to present two half-hour network television shows covering high points of the American Medical Association's sixth annual Clinical Session in December. Originating from Denver, the telecasts will highlight Session activities, including presentations of new surgical and clinical demonstrations, special scientific exhibits and other interesting medical features. The programs will be of interest to physicians who cannot attend the meeting as well as to the general public.

Present plans call for coast-to-coast coverage on two different nights during the meeting, December 2-5. Once again the programs are being sponsored by Smith, Kline and French, Philadelphia pharmaceutical firm.

RURAL HEALTH CONFERENCE SET FOR FEBRUARY 27-28

"Widening the Highway to Health" will be the theme of the eighth national Conference on Rural Health to be held February 27-28 at the Roanoke Hotel, Roanoke, Virginia. The day preceding the general sessions (February 26) will be devoted to an informal get-together of physicians, who are responsible for rural health programs in their respective states, to discuss "Doctor Participation in Community Programs."

The subject of financing rural medical care will be covered at Friday's sessions. An experience-and-accomplishment program to stimulate thought on "What Can I Do When I Get Home?" will be presented the last morning. The final luncheon speaker will tell what medicine is doing, in cooperation with other organizations and groups, to help America solve its health problems.

NEW RADIO SERIES ON SPORTS AND HEALTH

A new series of radio transcriptions dealing with sports and health subjects will be available about December 15 from the AMA's Bureau of Health Education for use by local radio stations. The programs are based upon on-the-scene interviews with Olympic winners in Helsinki, Finland, and with national champions and other outstanding sports figures in this country.

Topics cover personal aspects, athletic accomplishments, team practice and health values of sports. Among those interviewed were Bobby Brown, M. D., of the world's champion New York Yankees; Harrison Dillard, Olympic 100-meter hurdling champion, and Julius Boros, world's national golf champion.

PR CONFERENCE IN DENVER

The AMA's fifth annual National Medical Public Relations Conference will be held Monday, December 1—the day before the opening of the Clinical Session—at the Shirley-Savoy Hotel, Denver. Theme of the one-day meeting will be "Mutual Understanding . . . the Key to Better PR." The Conference program will be geared primarily for physicians. Members of the House of Delegates, officers of state and county medical societies, officers of the Association and executive secretaries and PR personnel are cordially invited.

RURAL HEALTH RADIO SERIES AVAILABLE

An eight-week radio transcription series on rural health entitled "Help Yourself to Health" will be released October 15 by the AMA's Bureau of Health Education to state and county medical societies. The series consists largely of true stories about small Amer-

ican communities which have successfully solved their health problems through local initiative and effort. Citizens from these communities tell the stories in their own words.

Verbatim comments used in the transcriptions were tape-recorded at the National Conference on Rural Health held in Denver. The series was produced by the Rocky Mountain Radio Council. Each program runs 15 minutes.

Covered in the series are such vital topics as "How Small Towns Can Get a Doctor," "How Small Towns Can Keep a Doctor," "Training Rural Doctors," "Working Together for Health" (health councils) and "Projects for Your Health Council." The theme that "self-help is the American way" runs throughout the programs.

NATIONAL CONFERENCE ON TRICHINOSIS

The American Medical Association has joined with the U. S. Public Health Service, the U. S. Bureau of Animal Industry, the American Public Health Association and the American Veterinary Medical Association in sponsoring a National Conference on Trichinosis. The meeting is scheduled for December 12 at AMA Headquarters, Chicago.

It is hoped that the Conference will stimulate interest in the need for further public education of the dangers of trichinosis. Doctors Leonard W. Larson, Bismarck, and J. J. Moore, Chicago, were appointed AMA representatives by the Board of Trustees.

FIRST AID GUIDE NOW AVAILABLE

Useful tips on how to handle common first aid emergencies have been compiled in a pocket-sized manual by the AMA's Council on Industrial Health and the Bureau of Health Education. The booklet outlines adequate first aid instructions for everyday illnesses and injuries in a simple way. It is designated to guide those who have not received formal first aid training as well as to refresh the memories of the experienced. A list of suggested items for a first aid kit also is included.

Single copies are available without charge through either of these AMA departments. Quantity prices will be supplied on request by the Order Department.

STUDENT AMA ANNUAL MEETING

Outstanding leaders in medicine and medical education will be featured on the program of the 1952 annual session of the House of Delegates of the Student American Medical Association December 29-30 at the Sheraton Hotel, Chicago.

Dr. Walter C. Alvarez, Chicago, will speak December 30 on "The Disappearing Art of Diagnosing with the Eyes and Ears." John Van Nuys, M. D., dean, Indiana University School of Medicine, will be the principal luncheon speaker the same day, discussing "A Dean and His Problems."

Also included on the intensive two-day schedule will be a luncheon given by the Blue Shield Medical Care Plans and a buffet supper by Abbott Laboratories of North Chicago.

It is hoped that state and county medical societies will lend enthusiastic support to local chapters of the SAMA by making sure that they are represented again this year.

BRITISH FILMS ADDED TO AMA LIBRARY

Two British films—"Some Aspects of the Cancer-Skin" and "Some Aspects of Cancer-Rectum"—will be available about October 1 from the AMA's Committee on Medical Motion Pictures. The films are suitable for professional meetings only.

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The Role of Conduction Anesthesia in the Diagnosis and Treatment of Disease*

R. E. EDMONSON
Spartanburg, S. C.

In recent years the use of conduction anesthesia or nerve blocks has come into more general use in the treatment of various disease processes and for the relief of painful disorders.

In 1934 Leriche and Kunlin introduced the idea of interrupting impulses along the sympathetic chain of nerves in the treatment of acute thrombophlebitis. Leriche believed that the segment of vein affected gives rise to vasoconstrictor impulses which disturb the normal resorption of lymph and tissue fluids. The consequent edema, in turn, causes further circulatory disturbances, so that a cycle is set up. His condition was that temporary breaking of the cycle will allow healing to begin.

Oehsner, in his work on acute thrombophlebitis and its successful management, by paravertebral sympathetic blocks, has confirmed this idea. He states that the prognosis in any given case is directly dependent upon the degree of spasm present.

Clinically, regional sympathetic paralysis results in regression of the local symptoms, cessation of pain, fall in temperature, and diminution of swelling.

Treatment by means of sympathetic block should be instituted as soon as the diagnosis is made. When the lower extremity is involved, ten cc of 2% metylocain is injected into the sympathetic chain at the first, second, and third lumbar ganglia on the affected side. When the upper extremity is affected, the injections are made into the stellate ganglion on that side. Some patients respond favorably to a single injection, while others require further treatment. Subsequent injections are performed daily; usually three treatments are sufficient. When the fever has subsided, the patient is allowed out of bed. Immobilization and prolonged bed rest are not necessary or advisable where regional sympathetic block is employed.

The incidence of embolism is about 15 per cent in thrombophlebitis treated by bed rest alone. However, when blocking of the sympathetic nerves is employed, the incidence of emboli falls to as low as 3 per cent.

There has been much discussion in the past several years of the efficacy of blocking the stellate ganglion in cases of cerebrovascular accidents. A number of cases have been reported where all evidence of paralysis has disappeared within twenty-four to forty-eight hours following the use of such therapy. However, to be beneficial, the block should be done within the first several hours following the accident. I realize that there are cases that clear up in this period of time without any specific treatment. Rovenstein has stated that blocking of the stellate ganglion will hasten the return of function in those who might ultimately recover, and will lessen the degree of paralysis in those whose functions will be impaired no matter what form of treatment might be used.

In 1943 Volpitto and Risteen reported the use of stellate block in twelve patients following cerebrovascular accidents. In four of these patients the diagnosis was in doubt as to whether hemorrhage, thrombosis, or embolus was the causative factor. These four patients were either comatose or semicomatose and no history could be obtained. None of them showed any response either immediate or delayed following the interruption of the sympathetic nerves with procain.

Seven patients of this group had occlusions of vessels due to cerebral thrombosis, and one patient had symptoms of cerebral vasospasm. The stellate ganglion, on the side opposite to the one involved, was injected in each patient. The time interval between the occlusion and the injection varied from a few hours to thirteen days. Six patients showed marked improvement objectively and subjectively from five to fifteen minutes following the infiltration of the procain, and then continued to improve gradually until dismissed from the hospital. Two patients did not appear to be improved until about eight to twelve hours later, and then a marked improvement was found.

These reporters emphasize that blocking of the stellate ganglion is definitely contraindicated in the presence of cerebral hemorrhage. However, where thrombotic or embolic phenomena appear in the

*Presented at Annual Session, S. C. M. A., May 15, 1952.

cerebral vessels, then interruption of the sympathetic impulses is indicated and may be of great benefit to the patient.

Blocking of the stellate ganglion has been advocated in the treatment of pulmonary emboli. In 1947 Bagent and Rapee reported the use of this therapy on three occasions in two patients. The first patient obtained relief, almost immediately, of bilateral chest pain on two separate occasions, although the stellate block was done only on the side of the infarction. He also had relief of severe dyspnea and orthopnea. The second patient was not in extremis, as was the first, but she, too, experienced relief of pain, chest constriction, and dyspnea that was not afforded by the use of opiates.

This therapy was instituted on the premise that pain impulses are transmitted by way of the sympathetic nervous system. This fact has been accepted by many in recent years as a definite entity. It is possible that the pulmonary embolus causes reflex vasospasm of the pulmonary vessels of not only the lung affected, but of the vessels of the opposite lung as well. This spasm initiates painful impulses that are mediated by the sympathetic fibres innervating these vessels. These painful impulses plus vasospasm could account for the severe chest pain, dyspnea, orthopnea, chest splinting, and resultant shock seen in patients having a severe pulmonary embolic syndrome.

In addition to reflex vascular spasm of the pulmonary vessels, there may also be a regional sympathetic spasm of the coronary vessels as well, regardless of the pulmonary involved, whether it is right or left. This premise would also explain the bilateral chest pain that may occur and the frequent cardiac irregularities found in many of these cases.

The use of stellate block is recommended in the treatment of coronary occlusion. Here again the object is to relieve the spasm of the coronary vessels, increase the blood supply to the heart, and to ease the pain and anxiety of the patient. This, in turn, increases the respiratory exchange and the oxygen consumption. The cyanosis and dyspnea is thus alleviated, and the patient is made more comfortable.

Interruption of the sympathetic impulses in the cervical region is used as a diagnostic procedure. Let me give you an example. A 35-year-old colored single male was admitted to the hospital on January 11, 1952, with a chief complaint of swollen right arm. His past history was negative as to injury or illness. However, he had been a heavy drinker and had consumed about a pint of whisky every night for several weeks. The night before admission he drank a lot of rubbing alcohol. When he woke up his right arm was markedly swollen and felt numb. A little later he began to have pain. He worked as a common laborer, but gave no history of any injury.

Physical examination revealed a very well built, muscular colored male in good physical condition except for marked swelling of the entire right arm

with several small blisters on the medial aspect of the upper arm and the lateral chest wall. No radial pulse was palpable and there was marked coldness of the hand extending up to the mid forearm.

Soon after admission to the hospital, a block of the stellate ganglion on the affected side was accomplished, using 1% metycain. There was immediate warming of the extremity and return of a full radial pulse. A dorsal sympathectomy was performed the following morning with subsequent diminution in the swelling of the arm. He was discharged from the hospital on February 2nd much improved.

During the past ten years much interest has been taken by anesthesiologists in the use of conduction anesthesia for the obstetrical patient. Hingson and Edwards, in 1942, proposed the use of continuous caudal anesthesia for deliveries. Due to technical and personnel difficulties, this procedure has been relegated to the larger medical centers.

However, this method of conduction anesthesia has a definite place in the armamentarium of the anesthesiologist. As a means of producing prolonged blocking of the sympathetic nerves of the lower extremities, it is a great aid.

Acute thrombophlebitis responds well to this method of blocking the lumbar sympathetics. Using the catheter technic, anesthesia may be maintained for a number of hours and, in some instances, obviate the need for repeated blocks, as is sometimes necessary when the paravertebral route is followed.

Intractable pain in the pelvic region may be relieved by continuous caudal analgesia. Perirectal cellulitis and abscesses may be rendered painless in the preoperative stage. Pain from ureteral calculi may be relieved by caudal block. The pain of sciatica is sometimes relieved by this procedure. Large doses of saline are sometimes injected into the caudal canal in an attempt to release adhesions about the sacral nerve roots.

Trimble and Morrison have emphasized the fact that intractable pain of visceral origin can often be relieved by interruption of the sympathetic nerve impulses. Blocking of these nerves will often determine whether permanent interruption by surgery is indicated.

Experience has shown that we often fail to relieve pain by diversion of the somatic nerves. However, if pain is present in an extremity, for instance, and affects there the distribution of a cerebro-spinal nerve, as in causalgia, it can be made to disappear if the condition of the peripheral circulation is altered either by infiltration with procain or the actual severances of the sympathetic nerves supplying the part. The anesthetizing of one system abolishes the pain that affects the other.

Eclampsia is another disease entity which has attracted the interest of anesthesiologists. Although the pathologic and physiologic process of this disease is poorly understood, it is thought that spasm of the terminal arterioles, especially in the kidneys, is a big

factor. Realizing that conduction anesthesia is used in the treatment of ischemia occurring in other pathologic conditions, Dr. P. C. Lund suggested its use in eclampsia. He reported the use of conduction anesthesia in the treatment of 22 patients. Sub-arachnoid block was employed in all cases. Following induction of anesthesia there was (1) a marked decrease in blood pressure; (2) cessation of convulsions; (3) increase in the output of urine; and (4) relief of headache, visual disturbances, and anxiety.

During the past year Marmer has reevaluated the use of sciatic nerve block as a means of producing vasodilatation in the lower extremity. It has been shown that the arteries of the extremities receive their nerve supply mainly from the peripheral spinal nerves, and, that in the lower extremities, the sciatic nerve carries the bulk of the sympathetic nerve supply.

He performed a comparative study of sciatic nerve blocks as compared to paravertebral lumbar sympathetic ganglion block. One approach was just as effective as the other. It was felt that, technically, blocking of the sciatic nerve was easier than the paravertebral route.

The use of nerve block for surgery has long been in use, especially in the debilitated and poor risk patient. There is today an attempt being made to relieve post-operative pain by the utilization of longer acting local anesthetic agents in producing nerve blocks. Nupercain-in-oil, and, lately, efocaine, have been of great help in this regard. Blocking of the intercostal nerves has aided materially in the early ambulation of pa-

tients following chest and abdominal surgery. These procedures have greatly decreased the need for large doses of narcotics post-operatively, and have speeded the recovery of patients. The incidence of complications has decreased, as has the length of time required for hospitalization.

Intercostal block is advocated in the treatment of fractured ribs. It is felt that strapping of the chest can be a dangerous procedure in some cases because of the possibility of pushing a fragment of bone through the pleura and thus producing a hemothorax.

During the second world war, there was an army directive sent to all medical officers instructing them to inject novocain locally into all sprains. This method of anesthesia can also be utilized for the reduction of fractures. Blocking of the brachial plexus is most expedient when fractures occur in the arm. Occasionally we see patients with severe cardiac disease who become dyspneic upon lying down, and any general anesthetic would be, to say the least, hazardous. However, these patients, too, suffer from fractures which have to be reduced painlessly.

In 1943, Tovell suggested the use of intravenous procain in 0.1% concentrations for transporting injured soldiers and during painful dressings as in the case of burns.

It is evident from these illustrations that research is proving that the anesthesiologist is no longer just a member of the surgical team, but is also a consultant who can help the general clinician in his diagnosis and treatment of disease.

The Mechanisms of Acid Base Balance of Clinical Significance*

L. CORSAN REID

Professor of Experimental Surgery
New York University Post Graduate Medical School
New York

Mr. Chairman, members of the South Carolina medical association and guests. Always, it is a great pleasure as well as a high privilege to be invited to address a group of one's colleagues. On this occasion it is particularly so, because I have had the good fortune to know long and well one of your distinguished members and his delightful and fascinating descriptions of South Carolina have brought me here with more than ordinary anticipation. In addition the renowned independence of spirit which is such a typical and characteristic feature of your people constitutes an inescapable challenge to one's evangelical propensities to attempt to arouse some intellectual indigestion or even actual rebellion against the wide-

spread and unnecessary abuse of parenteral fluid therapy.

INTRODUCTION

The mechanisms of acid base balance of clinical significance comprise all those physical and chemical processes whose dynamic equilibrium satisfy the fastidious and exacting demands of the cell for a relatively stable and constant cellular environment upon which depends cellular activity and even cellular existence. The cellular environment of course is the extra cellular fluid, and this constitutes a highway over which must pass all materials going to and coming from the cell. It is not particularly surprising therefore to find that the traffic on this road is governed by many alert and instantly available regulatory

*Delivered before the South Carolina Medical Association, Myrtle Beach, May 14, 1952.

mechanisms. Indeed, unless this were true, all the innumerable and interrelated processes whose aggregate constitute metabolism would soon rapidly and disastrously fall out of adjustment. This dynamic equilibrium in the interplay of so many complex and dissimilar forces had its origin somewhere in the neighborhood of 500 million years ago. As is well known to you, potassium constitutes cell base, and sodium represents the principal mineral in the extracellular fluid. It is interesting to point out that in those waters now bathing the earth's crust, such as the Pre-Cambrian Shield, which correspond to the Geological Conditions when life began, more potassium is present than sodium, and therefore one might expect potassium to be more abundant in cells.

With the progressive weathering of the rocks, more and more sodium was washed into the sea, and eventually it came to exceed all other minerals. Therefore, when the vascular tube first sealed off in Cambrian time, sodium was the dominant mineral in solution and the electrolyte ratios in Cambrian sea water are now perpetuated in those of Mammalian Blood Serum. The similarities in different species is illustrated by chart # 1 from MacCallum.¹

	Na	K	Ca	Mg
Ocean Water	100	3.6	3.9	12.1
Serum (human)	100	6.1	2.7	0.9
Dog	100	6.9	2.5	0.8
Cod	100	9.5	3.9	1.4
Crab	100	3.7	4.9	1.7
Jelly Fish	100	5.2	4.1	11.4

THE SIGNIFICANCE OF THESE ELECTROLYTE RATIOS ON THE BASIS OF THEIR PHYSICAL CONFIGURATION

The physical relationship of these electrolyte ratios to one another is frequently forgotten, but in view of the fact that these ratios represent an inherited endowment of 500 million years, it would be difficult to exaggerate their importance. Certainly, if sodium ions are in excess, cell activity is disturbed, and a similar situation occurs if any other electrolyte is in the ascendent. A good way to keep this organized in one's mind, is to recall how Sydney Ringer the eminent English Physiologist, in the early 1880's discovered the solution which now goes by his name. Ringer while working with perfusions of frog hearts noticed that if the perfusion fluid was isotonic sodium chloride, the frogs heart came to rest in about 10 minutes and could not be started.²

A most perplexing difficulty was that sometimes the heart would beat much longer than at other times. Through a series of fortuitous circumstances, he discovered that in those hearts which beat the longest, the lab boy had failed to distill the water with which the solution was made. Immediately Ringer realized that there were some minerals in the water which were beneficial, accordingly he added calcium which

gave him prolongation of diastole and then if he added potassium, he got a reasonably normal beat. This balanced mixture of course is now known as Ringer's solution. The point is, these ions—sodium, potassium and calcium have a counter balancing action on one another, which is completely independent of any chemical effects their salts may have. Ringer was well aware of the fact that it did not matter whether he used potassium sulfate or potassium chloride or potassium phosphate. The important thing was the potassium, and the calcium. Ringer actually anticipated from a physiological experiment the electrolytic dissociation theory of Arrhenius which was not published until 1887.

THE CHEMICAL RELATIONSHIP OF ELECTROLYTES

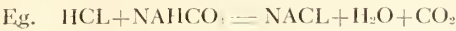
The chemical relationship of electrolytes illustrate another facet of this relationship. It has been known for a long time that the reaction of the body fluids must be slightly on the alkaline side, and that any actual acidity is not compatible with life. Therefore one means by an acidosis, not an actual acid condition of the blood or extracellular fluid, but a decreasing alkalinity. It should be made crystal clear at this particular time, that in modern clinical practice the term acidosis has two meanings, and alkalosis has two meanings. Acidosis means a decrease in the PH and a decrease in the amount of bicarbonate reserve. Now alkalosis means an increase in the PH or an increase in the bicarbonate reserve. Nearly always they move in the same direction at the same time. The important exceptions are hyperventilation, hibernation and emphysema. There is a very interesting historical background to these ideas, which is particularly pertinent to the subject under discussion.³

In 1874 Kussmaul pointed out the clinical similarity between diabetic and uremic coma. In 1877 Walter gave large amounts of hydrochloric acid to rabbits and found that the amount of sodium bicarbonate in their blood was proportional to the amount of acid given, and their clinical condition could be alleviated by giving sodium bicarbonate. In 1883 Stadelmann suggested that people in diabetic coma were like the rabbits of Walter. Accordingly a search for acids in the urine revealed them to be present, and bicarbonate solutions were used therapeutically.

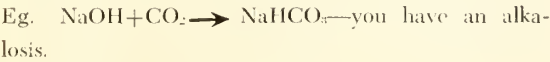
Subsequently, developments came quick and fast. But it is salutary for clinicians to remember that these concepts originated in the laboratory, and were only later and subsequently recognized in clinical medicine. The PH being a ratio between the acid elements and base elements, has been found to have a relatively small use in clinical medicine. But in the final analysis the PH of course is the sole arbiter.

From now on when we use the word acidosis we mean a decrease in the amount of available bicarbonate in the blood and by the same token by alkalosis, we mean an increase in the amount of bicar-

bonate in the blood. For example we will illustrate this with the following formula.



Therefore, one may see from this formula that the introduction of HCL into the plasma has used up some of the bicarbonate, with the formation of sodium chloride, a neutral salt, with no serious disturbance in the reaction of the blood. But the point to remember is that you now have less sodium bicarbonate than you had before, and therefore according to the definition you have an acidosis. On the other hand, if you introduce an alkalae like sodium hydroxide then plus the ubiquitous, and at all times available CO_2 one gets sodium bicarbonate and now you have more sodium bicarbonate than before, therefore:



It seems very much in order to point out at this time that notwithstanding the fact that this representation may be an over simplification, it is still of the very greatest clinical assistance, and its continuous use will demonstrate its immeasurable value.

Always, in medicine one has been taught the importance of having an anatomical or morphorological basis for the concepts of disease and this is as it should be. However, there are an increasing number of conditions in which no anatomical lesion can be recognized. But the principle is so sound, that in the case of acidosis, alkalosis dehydration, etc., one can substitute simple chemical diagrams as a basis for their concepts.⁴

The following is the Diagram of the Normal Plasma Pattern.

Quantities expressed in milli equivalents.

Chart #2

Na 142	HCO ₃ 27
	CL 103
K 5	PO ₄ SO ₄ 3
Ca 5	Proteins 16
Mg 3	Organic Acids 6

In all humility, one can assure anybody but an expert in this field that to remember this diagram, permits the ready objective visualization, and instant understanding of any disturbance of acid base balance that he is likely to run into. There is a great feeling among the profession that it cannot be as simple as this. But, nevertheless, this is a key which will unlock any clinical difficulty that one may meet in this field. A few characteristic patterns are illustrated here. These charts are simple arrangements of possible

plasma derangements. They are solely for the purpose of illustrating their usefulness. They are constructed after those of Gamble.⁵

Chart #3

Na 142	HCO ₃ 37
	CL 93
K 5	SO ₄ PO ₄ 3
Ca 5	Proteins 16
Mg 3	Organic Acids 6

VOMITING

Loss of 10 milli equivalents of chloride increase by HCO₃ therefore, alkalosis

Chart #4

Na 142	HCO ₃ 20
	Ketonic Acids 7
	CL 103
	SO ₄ PO ₄ 3
Ca 5	Proteins 16
Mg 3	O. A. 6

DIABETES

Ketonic acids to the amount of 7 milli equivalents appear in the plasma and corresponding decrease in HCO₃.

Chart #5

Na 142	HCO ₃ 17
	CL 105
K 5	SO ₄ PO ₄ 11
Ca 5	Proteins 16
Mg 3	Organic Acids 6

Nephritis

Here Cl SO₄ and PO₄ to the extent of 10 milli equivalents are retained in the plasma as a result of renal insufficiency. Corresponding decrease in the HCO₃

Chart #6

Na 142	HCO ₃ 35
	Ketones 8
	CL 87
	SO ₄ PO ₄ 3
Ca 5	Proteins 19
Mg 3	Organic Acids 3

Duodenal Obstruction

Here one sees severe vomiting in presence of starvation Ketones in plasma, to extent of 8 MEq but a loss of 16 MEq of CL and increase in HCO_3 by 8MEq. Therefore, a ketosis in the presence of an alkalosis.

CONSERVATION OF BASE

The conservation of base is essential to the well being of an organism because the acid radicals from an ordinary diet greatly exceeds the intake of fixed base. Therefore the mechanisms for its conservation must be briefly enumerated.

1. The synthesis of ammonia by the kidney, and its excretion in place of sodium. Thus ammonium chloride goes into the urine instead of the sodium chloride.
2. The ion exchange mechanism so beautifully described by Pitts, in which the Di Sodium Phosphate is changed in the kidney to Di Acid Sodium Phosphate. Eg. Na_2HPO_4 to NaH_2PO_4 .
3. The ability to spill organic acids in a certain proportion into the urine without covering base. and finally,
4. The excretion of an acid urine in the presence of an alkalosis in dehydration, illustrating in a very pointed fashion that the body conserves the level of the fluid in the body more efficiently than the reaction of the fluids.

REGULATION OF WATER BALANCE

The regulation of water balance or fluid volume in the body, depends upon the integrated functional activity of the kidney, adrenal cortex, pars nervosa and an adequate intake of sodium.

The distribution of the water in the body is, according to Gamble⁵ approximately 5% is in the blood plasma, 15% in the rest of the extra-cellular fluid and 50% in the intra-cellular fluid.

The amount of water utilized by the body in 24 hours, according to Gamble⁵ reaches the surprising volume 8200 cc, with the following composition:

Saliva	1500 cc
Gastric Juice	2500 cc
Bile	500 cc
Pancreas	700 cc
Intestine	3000 cc
<hr/>	
	8200 cc

In view of the fact that the fluid volume of the blood is of the order of 3500 cc, it is easy to see that over $2\frac{1}{2}$ times the total blood volume is utilized each 24 hours.

Therefore, the reabsorption of these fluids becomes a matter of critical importance. This explains the well

known clinical fact that diarrhea and vomiting most rapidly deplete the body fluids. The importance of sodium's crucial position in maintaining the fluid volume level is well illustrated by Chart #7 by Gamble and McIver. From Gamble⁵ In this experiment an external pancreatic fistula provided for a continuous loss of sodium. The dogs were given all they wanted to eat and drink except sodium. As you will see, no significant change occurred until the 11th day, except for a continuous loss in weight. Then, suddenly, when the reservoir of extra-cellular fluid was empty and no source to maintain blood volume was available plasma protein concentration increased. This was soon followed by death on the 13th day from dehydration, even in the presence of an abundant fluid intake. This fluid could not be retained however, because of a lack of sodium.

EFFECTS OF CONTINUED LOSS OF PANCREATIC JUICE.

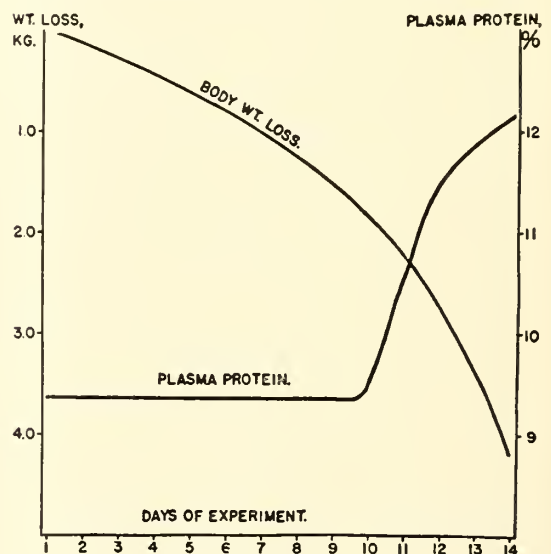


Chart #7.

TREATMENT

The treatment of disturbances of acid base balance can be summarized very succinctly.

Sodium chloride solutions will repair any defect of the plasma except a ketosis and low plasma potassium levels. Sodium and chlorine are metabolised separately. If a patient is vomiting chloride and you give sodium chloride, the chloride is retained and the sodium is spilled by the kidney. If an infant has severe diarrhea with a loss of base, the body retains the sodium and excretes the chlorine.

In the interesting condition of low potassium in the presence of alkalosis which has been described by McQuarrie⁶ in Cushing's Syndrome it is essential to add some potassium salts. At this particular point it is of the utmost importance to point out that low potassium levels cause a good deal of trouble and should be rectified whenever possible. But they rarely die from this condition. On the other hand hyperpotassemia is a real formidable danger. And it is sure that 10 milli-equivalents is lethal. So when in doubt do not give potassium. Nearly always the electrocardiograph will tip off the proper procedure to be employed. Now as to the question of glucose therapy a simple rule can be laid down. When glucose is given intravenously, 5 things happen:

1. Some spills by the kidney.
2. Some is converted to glycogen. This is indeed a small proportion.
3. Some is converted to fat.
4. Some is stored by the skin. What Cannon called storage by inundation.
5. An appreciable proportion of the glucose is metabolized to carbon dioxide and water.

This water in the blood stream without covering base through a mechanism which is to be discussed tomorrow, inhibits the formation of the antidiuretic hormone. This combined with the fact that when glucose is at or above the ceiling of its reabsorptive capacity in the kidney, the mechanisms for sodium reabsorption are in some measure less efficient. The result is some sodium is lost in the urine because of the presence of the high glucose. These two mechanisms explain why glucose is a diuretic. However, if one puts the glucose in a solution of saline only the glucose gives the free water which after all is very small. It is the water with the glucose which is so useful in supplying the physiological requirements and therefore, no purpose is served by this procedure which is such a widespread error in practice. Indeed, this cannot be insisted upon too much, as has been so pointedly mentioned by Gamble.⁷

Therefore, one can lay down the rule that glucose solutions have as their sole therapeutic value:

1. To act as a diuretic, to reestablish any disturbance of electrolyte ratios that result from renal inefficiency.
2. To supply the body with its daily requirements of physiological water. Under no circumstances can the pathological loss of fluids from vomiting, diarrhea, etc., be replaced by glucose solutions.

Glucose solutions have a protein sparing effect and to a lesser extent a sodium sparing effect also, so that one can approach treatment confidently by remembering these two simple rules. This explains why many patients are intelligently treated without any clear understanding of the precise derangement that is present.

SUMMARY

1. Potassium is the principal cell base in both plant and animal forms.
2. Sodium is the extra-cellular base in all animal forms.
3. Sodium, potassium, calcium and magnesium have a counter balancing neutralizing action upon one another entirely upon the basis of their physical configuration and independent of any chemical quality.
4. In clinical terms, acidosis is a decreasing alkalinity and alkalosis an increasing alkalinity.
5. The Conservation of Sodium is carried out by four very efficient mechanisms.
6. The fluid volume level in the body is maintained by the functional intergration of the kidney, pars nervosa, adrenal cortex and the adequate intake of sodium.
7. Sodium chloride solutions will repair any defect in the plasma except a ketosis and low plasma potassium and glucose solutions should be rigidly restricted to the physiological requirements of the body for water as a diuretic. To replace the pathological loss of fluids, sodium chloride solutions are essential.

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Hemochromatosis Complicated by Congestive Heart Failure and Severe Anemia: Report of Case

RAYMOND K. O'CAIN, M.D.,*

Fellow in Medicine,

Mayo Foundation,

University of Minnesota.

and

HARRY L. SMITH, M.D.,

Division of Medicine,

Mayo Clinic,

Rochester, Minnesota

In the past, hemochromatosis was not generally considered a cause of congestive heart failure. In recent years, however, more cases of hemochromatosis associated with congestive heart failure are being reported.

Report of Case

The patient, a farmer from Iowa 61 years old, came into the hospital on January 7, 1952, because of debility, dyspnea and progressive weakness. He had been well enough to carry on all the duties of his occupation until three years previously, when weakness, dyspnea on exertion and swelling of the legs had begun. Within a month or two he was unable to work and was hospitalized near his home. It was discovered that he was severely anemic and he received five transfusions in a week. There was no history of loss of blood. Injections of liver extract were begun and continued at intervals of a week until admission to the Mayo Clinic but no more transfusions were given. Although the patient felt better after the transfusions, he never regained his usual health and vigor. He continued to complain of weakness, his tolerance of exercise was low and there was some swelling of the feet and legs most of the time.

During the two or three months prior to admission to the clinic his condition had deteriorated further, weakness had increased and dyspnea appeared on the slightest exertion. Pain of an anginal nature began and was associated with the exertional dyspnea. The edema became more massive and after recumbency showed in his face about his eyes, as well as in the lower portion of his body. He complained of fullness in the upper part of the abdomen, a loss of appetite and inability to sleep because of cough and dyspnea. Some generalized itching had been present since the onset of his illness and in recent weeks this had become very annoying. He had not known of any jaundice though his family commented on his bad color. He gave no history of hypertension, rheumatic fever, syphilis, loss of blood or of previous myocardial infarction.

On examination at the clinic the patient appeared chronically ill and debilitated. He talked with difficulty because of dyspnea. The skin and mucous membranes were pale, but over the face and arms particularly there was hyperpigmentation of a dirty brownish gray type. The patient was edematous about the eyes and had massive pitting edema up to the sacral level. The skin showed numerous scratch marks.

The heart was enlarged, so that the apical impulse was felt in the sixth intercostal space well outside the left anterior axillary line. The heart tones were feeble and weak. The rhythm was regular, and the rate was 80 per minute. There was an inconstant apical systolic murmur, but no other abnormal sounds were heard. The lungs showed moist rales over both lower pulmonary fields.

On examination of the abdomen, a moderate amount of ascites and massive enlargement of the liver were noted. This organ extended to the level of the iliac crest; it was firm, had a sharp edge, a smooth surface and was not tender. The deep tendon reflexes were generally hypoactive.

The initial laboratory tests revealed the following values and findings: 4 gm of hemoglobin per 100 cc. of blood; 1,260,000 erythrocytes per cubic millimeter of blood; a slight amount of albumin in the urine; sedimentation rate of 83 mm. in one hour (Westergren); 40 mg. of urea and 120 mg. of sugar per 100 cc. of blood; negative result of the Kline test; no direct reacting serum bilirubin and 1.2 mg. of the indirect reacting type; 5.52 gm. of protein per 100 cc. of serum with 3.31 gm. of albumin and 2.21 gm. of globulin. An electrocardiogram showed no significant abnormalities.

The patient initially, then, presented evidence of advanced congestive heart failure, associated with severe anemia of long standing, a large hard liver, pruritus, and a peculiar type of pigmentation of the skin. Why the congestive heart failure was present, and the nature of the anemia were obscure.

Special blood smears were made and reviewed by consultants on diseases of the blood. They showed

*Now practicing in Orangeburg, South Carolina.

marked anisocytosis and poikilocytosis with hypochromasia, some target cells and scattered macrocytes. Polychromasia and fairly abundant normoblasts were noted. Examination of the sternal marrow showed that the principal cells in the preparation belonged to the normoblastic line, the majority being basophilic normoblasts. Many reticuloendothelial cells were present some of which contained hemosiderin. Myelopoiesis was not remarkable. Examination of the stool failed to show occult blood and the value for fecal urobilinogen was within normal limits. The bromsulfalein test of liver function was normal, there being no retention of dye.

Roentgenograms of the thorax confirmed the impression of marked cardiac enlargement. Roentgenologic studies of the stomach, duodenum and colon with the aid of barium failed to show any potential source of blood loss or any other abnormality.

In the way of symptomatic treatment the patient was cautiously given transfusions of whole blood. He was at the same time digitalized, placed on a dietary program of moderate restriction of sodium, and was given mercurial diuretics in standard doses. These measures resulted in prompt diuresis, and the patient lost a total of 18 pounds (8.2 kg.) in the course of two weeks. He became ambulatory and got about the hospital without distress. His nights were much better and he could lie flat.

Though the edema and ascites disappeared, the liver changed little in size or consistency. Because of the hyperpigmentation and the large firm liver with good function as measured by the dye excretion test, hemochromatosis was suspected. On January 21, 1952, a transabdominal needle biopsy of the liver was done. The pathologist reported finding hemochromatosis and cirrhosis and confirmed our suspicions. Biopsy of skin of the left forearm also contributed to the diagnosis of hemochromatosis.

The patient was dismissed. At that time the congestive heart failure was under control and the value for hemoglobin was 9.7 gm. per 100 cc. of blood; this level of hemoglobin was attained by transfusion, but without a satisfactory understanding of the nature of the anemia.

On March 11, 1952, the patient returned for re-evaluation. He had done fairly well on a program of limited activity until two weeks before his return, at which time he began to feel weak; dyspnea returned as did the edema of the feet and legs. He again denied any evidence of loss of blood. The pruritus of which he had complained on his previous visit had subsided.

The physical examination was as on discharge from the hospital except for a moderate degree of dependent edema and puffiness about the eyes. The patient was again pale despite the abnormal pigmentation. The pulse rate was 100 per minute and regular, the heart was enlarged, and the lungs showed only mini-

mal evidence of congestion. The condition of the liver was unchanged.

Laboratory findings of significance included: glycosuria, grade 1, 130 and 139 mg. of blood sugar per 100 cc. on two separate occasions on fasting; 4.8 gm. of hemoglobin per 100 cc. of blood; 1,150,000 erythrocytes; no direct reacting serum bilirubin and 1.2 mg. of the indirect type; hydrochloride acid was found in gastric contents after administration of histamine; reticulocyte counts were 0.3 and 0.4 per cent. Results of the antiglobulin developing test were negative; the stool was negative for occult blood. Examination of smears of the peripheral blood disclosed the same condition as on the previous visit.

The patient again had a satisfactory diuresis after administration of mercurials and the edema largely disappeared. He received two transfusions of 500 cc. of whole blood. He was given an appropriate diet for diabetes and appeared not to require insulin. When he was dismissed, he was feeling better, but the degree of his improvement was not so great as on the first visit.

Comment

Hemochromatosis is generally recognized as a metabolic disease characterized mainly by abnormal retention and deposition of iron in the form of hemosiderin throughout the body. The main pathologic features are the deposition of pigment, which shows an affinity for glands, the presence of fibrotic changes and cellular degeneration; the last is the least impressive finding. Hemochromatosis presents ordinarily as a clinical triad of abnormal skin pigmentation, diabetes mellitus and enlargement of the liver.

Although the metabolic nature of the disorder as championed by Sheldon¹ is generally accepted, Gillman and Gillman² have suggested that the condition which they referred to as "cytosisiderosis" is related to a deficiency state. Their conclusions are drawn from biopsy of the liver on malnourished Africans with pellagra, and they concluded that the source of the abnormal iron is the mitochondria of the parenchymal cells, which have been adversely affected by the deficiency state. They stated that hemochromatosis is a rather common complication of pellagra in Africans.

Previously detailed reports of cases of hemochromatosis in which the main manifestations were cardiac have appeared in the literature.³⁻⁶ From other reports, not presented primarily as examples of heart disease, it is apparent that the cardiac involvement was a significant part of the process.⁷⁻¹⁰ No longer is hemochromatosis considered a rare disease; more than 400 cases are reported in the literature. Of this number perhaps a dozen are predominantly cases of severe heart disease attributable to hemochromatosis.

In his monograph, Sheldon¹ stated that the heart was a site of deposits of hemosiderin in 90 per cent

of cases in which necropsy was performed. However, he did not list heart disease as an important clinical manifestation or cause of death in hemochromatosis.

Blumer and Nesbit,³ reviewing the French literature, discredited the so-called endocrinohepatocardiac syndrome. The main features of this are an age incidence definitely below the average for the disease, involvement of endocrine glands (particularly testicular atrophy), infantilism as a part of the clinical picture, and frequently death from apparent cardiac failure. The pathologic changes in the heart as reported in such cases are meager and the French propose that the cardiac failure is produced by endocrine effects rather than by myocardial damage secondary to the abnormal deposits of pigment.

The majority of cases reported in the English literature in which heart failure is a prominent feature does not seem to fit into this syndrome. Furthermore, in the cases coming to necropsy the hearts generally showed myocardial changes which seemed adequate to explain the failure. The hearts of persons with hemochromatosis who died of cardiac failure were generally reported to be enlarged. Brownish pigmentation was present, and the muscle was frequently described as soft and flabby. Microscopically there was intense infiltration of pigment in and about the muscle cells. In some areas the muscle substance appeared to be entirely replaced by the iron-containing pigment. Some hearts showed predominantly a replacement fibrosis; others showed little fibrosis but varying degrees of degenerative changes with fragmentation and lysis of the myofibrils. Some investigators have expressed the opinion that the heart failure is solely due to the damage of the heart muscle by the deposition of the pigment in the heart muscle resulting in marked fibrosis. Others consider that heart failure is due to endocrine disturbance. This latter school of thought cites cases of hemochromatosis in which the heart contains large amounts of pigment and the hearts have not failed. We favor the idea that both factors are causes of heart failure, as they apparently were in our case. There were no other etiologic factors apparent to produce heart failure, and the diagnosis seemed positive, with the clinical triad of diabetes, pigmentation of the skin, and enlarged liver, which on biopsy showed extensive deposits of hemosiderin and cirrhosis. The presence of pain in the thorax is not disconcerting because in the cases in the literature an anginal pain, and in one instance pain suggestive of myocardial infarction occurred with normal coronary arteries being found at necropsy.

Our patient responded well to the usual treatment for congestive heart failure. However, our period of observation is brief.

A more puzzling diagnostic and therapeutic problem in our case was the status of the blood. Anemia is not ordinarily a characteristic of hemochromatosis. In only 6 of the 311 cases reviewed by Sheldon¹ was the erythrocyte count less than 2,500,000. Anemia was

not present in the series of Butt and Wilder,¹¹ although macrocytosis was found in 3 cases.

There are scattered reports in the literature of the occurrence of severe anemia with hemochromatosis. Chesner¹² described the case of a 14-year-old boy who had had anemia for six years and for whom splenectomy was done for suspected Banti's disease. This patient was said to have a hypochromic microcytic type of anemia with a hyperplasia of the erythroid elements in the sternal marrow. He was not benefited by splenectomy and the effect of blood transfusion was short-lived. This patient did not have pigmentation of the skin or diabetes and the diagnosis of hemochromatosis was not established until necropsy.

Zeltmacher and Bevans¹³ reported the case of a man, 65 years old, who had dyspnea and edema and a severe anemia which required transfusion. The bone marrow was cellular and showed an increase in normoblastic activity; hemosiderin was present in the reticular cells. There was no evidence of loss of blood and the anemia failed to respond to injections of liver and iron. The patient died of anemia and heart failure, and the diagnosis of hemochromatosis was established at necropsy. These authors commented on several other cases of refractory anemia associated with hemochromatosis and expressed the belief that the relation between the two diseases is more than coincidental.

Bomford and Rhoads¹⁴ in their extensive report on refractory anemias stated that in the "pseudo-aplastic" type of anemia (with a relatively normal marrow) pigmentation of the skin sometimes occurs as a complication and less frequently hemochromatosis. They described 3 cases of hemochromatosis associated with refractory anemia. One of these patients had received fifty-four transfusions and the others "not an exceptional number." It appears that hemochromatosis can develop as a complication of severe refractory anemia.

The distinction between advanced hemosiderosis and hemochromatosis is not always absolute. Reports of approximately 40 cases of transfusion siderosis have appeared in the literature; these are mostly cases of pernicious anemia, refractory anemia and chronic leukemia. Schwartz and Blumenthal¹⁵ discussed the problem of exogenous hemochromatosis resulting from transfusion of blood. In the cases cited from twenty-one to 290 transfusions had been given.

The stores of iron in the normal body are about 5 gm., more than half of this being in the hemoglobin. In cases of well-developed hemochromatosis the body contains 25 to 50 gm. or more of iron. The average amount of iron in the usual transfusion is about 250 mg. Thus it is seen that an enormous number of transfusions would be required if this were the only source of excess iron in "transfusion hemochromatosis."

In the absence of blood loss there is no avenue of escape for the body's stores of iron. The loss of iron

through pregnancy and menstruation probably accounts for the lesser incidence of hemochromatosis in the female. Recently there has been reported by Davis and Arrowsmith¹⁶ beneficial results from repeated phlebotomies in patients with hemochromatosis.

In our case, the anemia seemed definitely not related to loss of blood and we could not produce any evidence of abnormal hemolysis. Since the marrow was normal or actually hyperactive in appearance, without maturation arrest, the anemia has to be regarded as an achrestic or adynamic type of anemia, the ultimate cause of which is not at all known.

Although we were aware of the fact that the patient's stores of iron would be slightly increased by transfusion and thereby possibly the hemochromatosis made worse, there seemed no alternative but to give blood. We made no attempt to curtail the dietary intake of iron.

Summary

In the case of hemochromatosis presented severe congestive heart failure was complicated by refractory anemia. The diagnosis of hemochromatosis was established during life by liver biopsy. The literature on heart failure and anemia occurring in hemochromatosis was considered.

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CANCER

Edited by JOHN C. HAWK, JR., M.D., Charleston, S. C.

CARCINOMA OF THE PENIS

KENNETH M. LYNCH, JR., M. D.*

This study was supported in part by a cancer training grant from the National Cancer Institute of the National Institutes of Health, United States Public Health Service. From the Department of Urology and the Cancer Clinic, the

In 1931 Lewis¹ observed that cancer of the penis constituted almost ten per cent of the malignancies of the genito-urinary tract admitted to The Brady Urological Institute of the Johns Hopkins Hospital. Horn and Nesbit² noted in 1934 that approximately 225 deaths occur in the United States each year as a direct result of cancer of the penis. Certainly it occurs with sufficient frequency to warrant careful evaluation of the means of treating this malignancy.

Procedures of varying magnitude have been reported in the literature as the operation of choice for cancer of the penis. These encompass, at the extremes, a simple amputation with a reasonable margin of grossly uninvolved tissue, and the classic radical operation of Hugh Young comprising total amputation of the penis together with en bloc dissection of the inguinal and femoral lymphatics and of the scrotum and its contents. In the passage of time since 1907 when Young reported his operation, urologists have come to accept simple amputation as adequate in selected early cases and to feel that Young's operation is unjustifiably radical insofar as emasculation is concerned and insufficiently radical when the cancer has metastasized to the regional lymphatics. Furthermore, the classic Young abdominal crescentic incision has resulted in primary healing in few cases, thereby necessitating prolonged hospitalization while the wound heals by second intention, resulting in greatly increased expense, either to the patient or to the supporting agency. For the above reasons, the writer has been dissatisfied with the so-called radical operation and five years ago abandoned it for the procedure which is subsequently described and which has resulted in a significant decrease in the length of hospitalization in most cases.

PATHIOGENESIS

Cancer of the penis arises from the glans penis and is to be differentiated from carcinoma of the urethra which is rare and which has recently been thoroughly considered in a report by McCrea.³ Carcinoma arising from the glans penis is invariably squamous cell or epidermoid in character. The neoplasm is usually of grade I or II activity according to the classification of Broders and metastasizes relatively late as compared

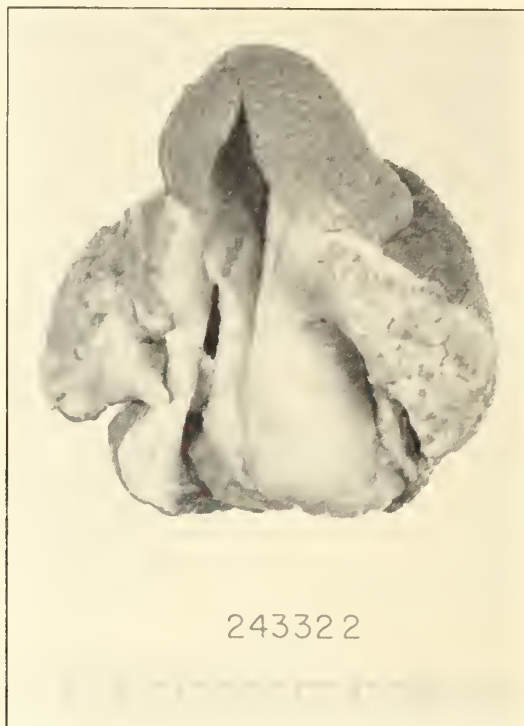


Figure 1. Photograph of surgical specimen showing ulcerating carcinoma of the penis.

to other malignancies. The early lesion may appear as an ulceration with a raised, rolled edge (Figure 1) or it may be a protruding, fungating, cauliflower-like growth (Figure 2). Either type spreads by direct extension, eroding and eventually destroying the glans penis and penile shaft. Metastasis is by the lymphatics to the inguinal and femoral chains, and subsequently to the iliac and periaortic systems, terminally involving the mediastinal lymph nodes. Rarely is there blood-borne metastasis, although we have seen one case in the Cancer Clinic in which there were peripherally located pulmonary metastases simulating those from clear-cell carcinoma of the kidney (hypernephroma). Even more rarely, metastasis takes place by way of lymphatics connecting the penis directly with the deep pelvic nodes through the epigastric channels by-passing the inguinal and femoral lymphatics.

It is now general knowledge that carcinoma of the penis occurs rarely in the circumcised, the neoplasm being almost unknown in the races and religious sects practicing ritual circumcision of the infant male. It has been postulated that smegma may be the carcinogenic agent. Recent reports in the literature have cited the comparative rarity of cancer of the cervix uteri in Jewish women, and have raised the possibility

Medical College of South Carolina, Charleston, South Carolina
*Assistant Professor of Urology, the Medical College of South Carolina



Figure 2. Photograph of surgical specimen showing fungating cauliflower-type lesion of penis and replacement of inguinal lymph nodes by metastatic carcinoma.

that smegma may be the carcinogenic agent in cervical cancer as well. Plaut and his associates⁴ have induced with smegma changes resembling cancer in skin tunnels in mice. Dr. H. R. Pratt-Thomas of the Department of Pathology of the Medical College of South Carolina and his associates are investigating whether cancer of the cervix can be induced by human smegma in the laboratory animal.

DIAGNOSIS

All suspicious lesions of the glans penis should be considered malignant until proved otherwise. Differential diagnosis includes carcinoma of the urethra, chancre, chancroid, lymphopathia venereum, granuloma inguinale, pyogenic balanitis, balanitis xerotica obliterans, and erythroplasia of Queat. All too often, patients are given long courses of penicillin and referred to the urologist or the Cancer Clinic only after erosion of the penile shaft is present, at which time metastasis may already have occurred. Reliance in "faith healers" has resulted in some cases being seen in the Cancer Clinic after the neoplasm has eroded and involved the symphysis pubis, at which point the tumor is inoperable.

Conclusive diagnosis is achieved only by biopsy and microscopic examination of tissue sections. If the biopsy material shows carcinoma, the patient should be admitted for the appropriate surgery without delay. We are in agreement with Hudson, Cason and Scott⁵ that biopsy of enlarged inguinal lymph nodes is inconclusive and often misleading. A "negative" biopsy in such cases means nothing, as the surgeon may have selected the only node not involved by the neoplasm. On the other hand, enlarged inguinal nodes do not necessarily mean that metastasis has taken place. The primary tumor invariably becomes secondarily infected in the course of time and often causes a regional hyperplastic lymphadenitis.

SELECTION OF OPERATION

We do not dispute the opinion of some urologists⁶ that simple amputation of the glans with a cuff of

grossly involved penile shaft is an adequate and curative procedure in early cancer of the penis. We still prefer, however, to remove the superficial regional lymphatics so that a conclusive prognosis can be obtained.

We consider inoperable those cases in which (1) the symphysis pubis has been involved by direct extension of the neoplasm, (2) the regional lymphatic metastases have ulcerated through the skin and infiltrated the underlying fascia and muscle, (3) the excretion urogram shows lateral displacement of the ureters by enlarged periaortic lymph nodes, or (4) the chest x-ray film shows pulmonary metastases or widening of the mediastinum by enlarged lymph nodes. Simple amputation of the penis with its primary lesion may sometimes be useful for palliative purposes in cases having distant metastases but no gross ulceration of the groins. Roentgen ray therapy is of little benefit in penile cancer.

The majority of cases of penile cancer seen in the private practice of the author and in the Cancer Clinic of the Medical College of South Carolina do not represent early lesions, but at the same time they do not present distant metastasis or technically inoperable local extension. In most cases, therefore, the operative procedure mentioned in the introduction of this paper and described below is considered at the time this paper is written to be the operation of choice.

TECHNIQUE OF OPERATION

1. *AMPUTATION OF PENIS.* If the tumor is confined to the glans penis and its immediately adjacent tissues, a mid-shaft amputation of the penis is performed, leaving an appendage which is functional for direction of the urinary stream and for coitus. If the shaft proper has been invaded by the neoplasm, total amputation of the penis is performed and the stump of the urethra brought out through a stab-wound in the perineum midway between the anus and the junction of the scrotum with the perineum. These patients are able to urinate satisfactorily in the sitting position. In our experience, the use of a tourniquet about the base of the penis is not necessary. Clamps are placed across the corpora cavernosa at the desired level and mattress suture ligatures of chromic catgut are placed and tied before the clamps are removed. It is mandatory that the skin be divided at a sufficient distance distal to the amputation of the corpora cavernosa to allow coverage of the stump without tension. Whether a shaft amputation or total amputation is performed, an adequate length of corpus spongiosum with urethra should be preserved to allow at least two centimeters to protrude beyond the skin edges. The urethral stump may be incised in "fish-mouth" fashion and sutured to the skin or it may be allowed to protrude and slough off. Either method will result in a satisfactory urinary meatus.

We formerly proceeded with the regional lymphatic



Figure 3. Photograph of patient 12 days after second-stage operation showing bilateral longitudinal parallel groin incisions. The penis has been amputated and a perineal urethrostomy performed.

dissection immediately following the penile amputation. We now feel that the presence of infection locally and in the regional lymphatics makes primary healing of the inguinal wounds less likely and we prefer to perform the groin dissections at a second sitting approximately a week later, during which period the patient is administered antibiotics.

II. GROIN DISSECTION. Hudson, Cason and Scott⁵ found that 33 of 70 cases of penile cancer, or 47.1 per cent, had metastases to the regional lymphatics at the time of operation. For this reason, we feel that en bloc dissection of the inguinal and femoral lymphatics should be routinely performed. Suspicious lymph nodes should be selected from the surgical specimen for immediate frozen section and microscopic examination. If metastatic carcinoma is demonstrated in these nodes, dissection of the deep iliac lymphatics should be proceeded with.

As mentioned in the introduction, we have abandoned the classic lower abdominal crescentic incision as used by Young because of the almost inevitable break-down of the wound due to devitalization of the undermined skin flaps. We now employ bilateral parallel longitudinal incisions directly over the inguinal and femoral lymphatics which require little undermining of the skin flaps. As a result, primary healing is obtained in most cases. In closing the wounds, it is important to suture the skin edges to

the muscle fascia in order to obliterate the dead space and prevent pooling of serum. Leaving a rubber drain at the dependent end of the wound and the application of pressure dressings seem to hasten the healing process. Figure 3 shows one of our patients 12 days following the second stage of the operation with firm primary healing. Total amputation of the penis and perineal urethrostomy were necessary in this patient at the first stage operation. Figure 4 shows the blocks of tissue removed from the groins in this patient.

RESULTS

Operative mortality. Five cases from the Cancer Clinic and two cases of the writer have been subjected to the above operation with no deaths. Hudson, Cason and Scott⁵ reported a seven per cent mortality in 70 cases subjected to the Young operation over a period of 40 years. Although these authors do not analyze the deaths, we assume that they were probably due to sepsis in the days prior to chemotherapy and the antibiotics. Inasmuch as virtually all cases of cancer of the penis occur in comparatively young individuals, there should be a negligible mortality rate. There is minimal blood loss during both the penile amputation and the groin dissection. We have noticed no tendency to shock in our series of cases.

Survival. In the Johns Hopkins Hospital series cited previously,⁵ 46 per cent survived operation five years



Figure 4. Photograph of tissue removed en bloc from the groins in the second-stage operation.

or longer. Of 19 patients having metastases at the time of operation, six lived five years or longer. Our own series is too young and too small to provide statistics on survival. It is our opinion, however, that more of the patients in the Johns Hopkins series would have survived five years had dissection of the deep pelvic lymphatics been carried out when metastasis was demonstrated in the superficial regional lymphatics.

Healing. In our series, utilizing the bilateral groin incisions, primary healing with short hospitalization has been achieved in two-thirds of the cases. We have had wound slough and healing by second intention in only one patient subjected to the two-stage procedure.

SUMMARY

All suspicious lesions of the glans penis should be considered cancer until proved otherwise. The physician should not exclude malignancy from his differential diagnosis because the patient is in his twenties or thirties; most of our cases have occurred in this age group.

It is now established that cancer of the penis rarely, if ever, occurs in the circumcised. For this reason, it is strongly suggested that all males be circumcised in infancy.

We believe that all operable cases of penile cancer should have superficial regional lymphatic dissections. If metastasis is demonstrated in the superficial lymph nodes on frozen section, the deep iliac lymphatics should be removed.

The two-stage operation and bilateral longitudinal groin incisions are recommended as time-saving in hospitalization because of the greater incidence of primary healing than with the Young classic crescentic abdominal incision. The operative mortality is negligible.

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SULFA AND THE ANTIBIOTICS

With the coming of winter and the greatly increased incidence of respiratory infections, doctors will be confronted anew with the necessity for giving antibiotics and the sulfonamides. More and more the public is beginning to expect, yea, even to demand, that one of these drugs be used when treating any infection—be it just the common cold—and the conscientious doctor finds it hard to maintain a scientific balance in his use of these potent weapons.

No hard and fast rules can be laid down for doctors as they contemplate the use of these "wonder drugs," and yet certain simple principles might be employed which would prevent trouble:

Consider each case on its own merits and do not adopt any set routine for the treatment of different infections.

Make a definite diagnosis—if it is possible—before instituting treatment.

Do not use an antibiotic or one of the sulfonamides unless there is a clear indication for so doing—an indication which would stand up before a consulting physician.

Watch carefully for side reactions, and always inquire as to whether a patient has had the drug on a previous occasion before prescribing it.

When using chloromycetin, have a hemoglobin and leucocyte study made twice a week.

When using the sulfonamides for any length of time, make repeated studies of the blood and urine.

When using the drugs in children, adapt the dose to the weight of the child, not to the age.

Discontinue the drug as soon as possible, except in those rare cases where it must be continued for a length of time. (Failure to stop the giving of these drugs in hospital patients has caused great waste and has increased the most of hospitalization immeasurably).

Be a doctor of medicine and prescribe for your patients yourself—don't let them tell you what to give.

ARMY MEDICAL EXAMINATION

It was our duty and privilege recently—being just two weeks short of the age limit—to join some two hundred other physicians in the state in a medical examination at Fort Jackson to determine our fitness for military service. It proved to be an interesting experience and at the same time brought back memories of a decade ago.

The examination itself was in marked contrast to that experienced by many of us during 1941 and 1942 when we volunteered for service, only to be turned down for physical disabilities or else to be declared "essential" by Procurement and Assignment and told to stay at home. Instead of walking around in the covering in which we had come into the world we were afforded bathrobes and slippers. The medical officers were courteous and we were treated as colleagues. Every effort was made to speed up the work and such delay as prevailed was understandable. For all of this, we are duly grateful to Col. Gates, Chief Medical Officer at Fort Jackson.

Most of the men we saw who went up for the examination were over forty and many were pushing fifty. Many of them had been turned down for physical ailments ten years ago and they presented a picture of physical fitness which is hardly conducive to becoming a part of the U. S. Army today. But the spirit of the men was excellent. Most of them realized full well that this entire procedure was but a nation-wide inventory of the man power available among the doctors who were not yet fifty one and who had not served in World War II, and that the chances for those over forty years of age being called up for actual service was minimal. But we heard no complaining and a spirit of joshing and kidding prevailed. There were a few who had completed their medical education since 1946 and for these men it was serious business—and yet they knew that military service lay ahead and they accepted the fact with no complaint.

As we went down the line we could not but think of the difficult times which had faced us in 1942.

Physicians in South Carolina were patriotic. Before and after Pearl Harbor, doctors were volunteering in every county. When a quota for each state was finally established in October of 1912, South Carolina already stood at 174% (which is to say, South Carolina had given to the armed services 74% more doctors than the armed forces expected her to give). We were second only to Alabama in the entire nation. It was during this time that the Chairman of Procurement and Assignment for South Carolina, Dr. "Buck" Pressly, had so many difficult decisions to make. Uncle Sam was calling for doctors, but so were the people of South Carolina—and it was no easy task to say which doctors were "available for service," and which were "essential." Let it be said to the credit of the doctors of South Carolina that there were only four men who were declared "available for military service" who did not eventually wear a uniform. And there were dozens of others who were anxious to go who were denied the privilege by Procurement and Assignment and were told to stay on the home front.

The situation on the home front in South Carolina was critical during the early years of the war so far as medical care was concerned. A study was made by Mr. Marshall Pickens of the Duke Endowment in 1942 on "The effects of the war on the medical service in 12 South Carolina counties with limited medical personnel," and appeared in the September issue of this Journal in that year. The counties which he studied were Abbeville, Allendale, Bamberg, Barnwell, Berkley, Calhoun, Edgefield, Fairfield, Hampton, Jasper, McCormick, and Saluda. In 1940 the ratio of physicians to population in these counties was 1:2,485. By 1942 it had risen to 1:3,326, (the lowest was 1:2,495 in Hampton and the highest was 1:5,703 in Saluda). In a later study made by this Journal and published in January of 1943, the ratio of active physicians to population for the entire state (this did not include public health physicians or those men who were devoting their full time to institutions) was 1:2,264. It was indeed providential that no severe epidemic of influenza occurred in South Carolina during that period.

What the future holds no one can fortell. It is our sincere hope, however, that should another world war come provision will be made for the registration of every physician, making him subject to call, and that a plan similar to Procurement and Assignment of World War II will be established—but established immediately and not many months after the war has started, as was the case in World War II. Only in this way can a fair and just use be made of the doctor-power which is available throughout the country.

DEATHS

ARTHUR LLOYD BLACK

Dr. Arthur Lloyd Black, 67, Bowman physician, died on October 19, in a hospital in Birmingham, Alabama. He had been visiting his son, Dr. Arthur Black, Jr., in Birmingham.

A native of Saluda County, Dr. Black attended Newberry College and was graduated from the Medical College of South Carolina in 1912. Soon after his graduation he began practicing in Bowman where he practiced for more than forty years. He was a former mayor of Bowman and was active in religious and civic work of the town.

Surviving Dr. Black are his widow, two daughters and two sons.

NEWS ITEMS

Dr. John M. Preston of Columbia has been elected President of the South Carolina Public Health Association.

Dr. William Smith of Great Falls has opened an office at Fort Lawn and plans to be there each Tuesday and Saturday afternoon.

The South Carolina Heart Association will hold its annual meeting in Greenville in February.

Dr. G. P. Joseph of Myrtle Beach attended the Sixth Annual Assembly of the World Medical Association held in Athens, Greece, during October.

Dr. J. A. Tobin and his wife, Dr. Mary T. Tobin, have opened their offices in Denmark for the practice of general medicine.

Dr. Fred H. Fellers and Dr. John E. Holler of Columbia, have been named Fellows of the American College of Surgeons.

Dr. A. Richard Johnston of St. George, was elected president of the Coastal Medical Society, at a recent meeting in Walterboro. Other officers are Dr. C. B. Woods of Walterboro, Vice President, and Dr. Holland Carter of Smoaks, secretary-treasurer. Guest speakers at the meeting were Dr. M. W. Beach of Charleston and Drs. Frank Owens and Charlie Mitchell of Columbia.

Dr. John Homer Mathias, Jr. has opened offices in West Columbia for the practice of general medicine.

The Nineteenth Annual Meeting of the American College of Chest Physicians will be held at the Hotel New Yorker, New York City, May 28-31, 1953.

Physicians who wish to present papers at the meeting should submit titles and abstracts to Dr. Arthur M. Olsen, Chairman, Committee on Scientific Program, American College of Chest Physicians, Mayo Clinic, Rochester, Minnesota.

TENTATIVE PROGRAM

Fifteenth Annual Symposium
Duke University School of Medicine
Durham, North Carolina
December 9 - 10, 1952

ADVANCES IN THERAPY

Tuesday, December 9, 1952

- 2:00 - 3:30 P. M.—Dr. L. J. Meduna, Professor of Psychiatry, University of Illinois, Chicago, Illinois. "CO-2 treatment of psychosomatic disorders."
3:30 - 4:30 P. M.—Dr. James Toman, Division of Neurophysiological Research, Psychosomatic and Psychiatric Institute, Michael Reese Hospital, Chicago, Ill. "Mechanism of Action in Relation to Clinical Effectiveness of Anti-convulsant Drugs."
4:30 - 5:30 P. M.—Dr. C. P. Rhoads, Director, Memorial Center for Cancer and Allied Diseases; Professor of Pathology, Sloan-Kettering Division, Cornell University Medical College. "Trends in the Management of Neoplastic Disease."

INTERMISSION

- 8:00 - 9:00 P. M.—Dr. Harry Eagle, Chief, Experimental Therapeutics, National Microbiological Institute, National Institutes of Health, Bethesda 14, Maryland. "Antibiotic Therapy."
9:00 - 10:00 P. M.—Dr. J. Maxwell Chamberlain, Associate Surgeon, Columbia University College of Surgeons; Associate, Visiting Chest Surgeon Bellevue Hospital, New York, N. Y.; Attending Thoracic Surgeon, Roosevelt Hospital, New York, N. Y. "Segmental Resection in the Surgical Treatment of Pulmonary Tuberculosis (400 cases)."

Wednesday, December 10, 1952

- 9:00 - 10:00 A. M.—Dr. Charles P. Bailey, Professor and Head, Department of Thoracic Surgery, Hahnemann Medical College and Hospital, Philadelphia, Pa. "Intracardiac Surgery."
10:00 - 11:00 A. M.—Dr. Lewis Dexter, Physician, Peter Bent Brigham Hospital; Assistant Professor of Medicine and Tutor in Medicine, Harvard Medical School. "Pathological Physiology of Mitral Stenosis and its Surgical Implications."
11:00 - 12:00 P. M.—Dr. Samuel A. Levine, Physician, Peter Bent Brigham Hospital, and Clinical Professor of Medicine, Harvard Medical School. "A Cardiologist's View of Mitral Valvuloplasty."
2:00 - 3:00 P. M.—Dr. Irving S. Wright, Professor of Clinical Medicine, Cornell University Medical College; President, American Heart Assoc. "Modern Treatment of Myocardial Infarction."
3:00 - 4:00 P. M.—Dr. Joseph J. Bunim, Chief, Arthritis & Rheumatism Branch, National Institute of Arthritis and Metabolic Diseases. "Recent Observations on Prevention and Treatment of Rheumatic Fever."

BOOK REVIEWS

For Boys Only, By Frank Howard Richardson, M. D. Cloth. \$2.75. Pp. 91. Tupper & Love, Inc., 1090 Capitol Avenue, S. E. Atlanta, Georgia. October 1952.

For Boys Only is refreshingly new in its approach and style. It is most interesting and is written in a modern breezy way. Yet there is no sacrifice of clear, concise English which is easily understood. While the book is intended for boys between the ages of about 10 to 16 years, singly or in groups, it never talks down to them, never evades an issue and does not compromise. It is by no means just a sex manual or another text book.

The author, a well known doctor and lecturer, has already done much for children, and does not believe that pediatrics should deal with diseases only. In this volume one will find subjects discussed frankly, but without eroticism. There is nothing said that could unwisely stimulate a youth's curiosity in matters of sex, but there is constantly an attempt to answer questions that naturally occur to a young boy. Doctor Richardson does not preach at his boys, neither does he look for perfection. In answering questions supposed to have been put to him; and in giving the essentials of anatomy and physiology of the generative tract he does not become pedagogic, nor does he use words that are too technical. He meets his boys on their own level, without sanctimony or mystery. The author constantly tries to have each boy learn the truth about himself. Then if he elects to keep control of his desires and passions at all times he will later on be glad that he did what was best for him, his male and female companions and society.

Doctor Frank H. Richardson might have entitled this little volume: Common Sense about Sex or The Truth Shall Set you Free, but his wording is more consistent with the text. Since this book is made up of chapters, each being on a separate subject, and as all his statements are replies to questions, the reader does not tire and is stimulated to read on so as to see what comes next.

This unusual and attractive addition to pediatric literature should be well received by doctors, parents and those interested in the welfare of children.
R. M. Pollitzer, M. D.

CORRESPONDENCE

October 11, 1952

Journal of the South Carolina Medical Association
Letter to the Editor

Recently there have been news items in many papers in the state calling attention to the fact that doctors in Priority III are being called up for pre-induction physical examinations. This has brought forth a storm of discussion among us, probably unequaled since the present amendment to the Selective Service Act was adopted. Why all the discussion? No one seriously objected when Priority I men were called; likewise, the call of Priority II men brought forth little comment or objections. Why the present storm? The answer is this: All Priority I men have not been called.

Why? Will they be called or have they been deferred indefinitely? Many Priority II men have not been called. Why? Will they be called, or will they be deferred indefinitely?

I believe that every doctor in South Carolina is entitled to the following information at the earliest possible moment, either through the medium of the Journal or through letters to each county medical society. Every doctor has the right to know and should know:

1. The names of all men in Priority I who have not been called for service and the reasons why.
2. Names of all Priority II men who have not been called for service and the reasons why.
3. Names of all Priority III men and the order in which eventually they are to be called according to law.

I do not mean to infer that the Medical Advisory Committee has not and is not doing a good job. However, I believe every physician in South Carolina should have, and would like to have, full information as to where he stands and where other members stand on the matter of military service to his country.

I myself am in Priority IV.

Harry C. Tiller
Georgetown, S. C.

cc: Dr. Frank C. Owens
1319 Laurel St., Columbia, S. C.
Dr. Lon Weston
Wine St., Mullins, S. C.

October 15, 1952

Dr. Julian P. Price
117 W. Cheves Street
Florence, South Carolina
Dear Dr. Price:

The South Carolina Heart Association will have their annual meeting in Greenville, South Carolina, on Tuesday February 3rd. Dr. Schulze is the Program Chairman.

I understand that we are to have some outstanding speakers on the program as well as a report from Dr. John A. Boone on activities on research on heart disease of the Medical College in Charleston, and I am just wondering if it wouldn't be a good idea to put a notice in the South Carolina Medical Journal. We will, however, send invitations to all of the doctors of the South Carolina Medical Association and a program.

With kindest personal regards, I am

Very sincerely yours,

H. M. McElveen

Executive Secretary

WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. W. O. Whetsell, Orangeburg, S. C.

Publicity Secretary: Mrs. N. D. Ellis, Florence, S. C.

MRS. W. O. WHETSELL, MEDICAL AUXILIARY HEAD, PRESIDES AT STATE EXECUTIVE MEETING

The executive board of the Woman's Auxiliary to the South Carolina Medical Association convened at the home of the president, Mrs. W. O. Whetsell, in Orangeburg on October 2. Present for the meeting were state officers, county presidents, committee chairmen, members of the advisory council and other distinguished guests. State officers attending the meeting were Mrs. David A. Wilson of Greenville, president-elect; Mrs. A. T. Moore of Columbia, first vice-president; Mrs. W. P. Turner, Jr. of Greenwood, third vice-president; Mrs. C. R. May, Jr., fourth vice-president; Mrs. B. J. Workman of Woodruff, treasurer; Mrs. V. Wells Brabham, Jr. of Orangeburg, corresponding secretary; Mrs. M. J. Boggs, recording secretary; Mrs. John A. Seigling of Charleston, historian; and Mrs. T. A. Pitts of Columbia, parliamentarian.

County presidents representing their local auxiliaries were Mrs. W. H. Spiegsegger of Charleston; Mrs. Hyman Marcus of Orangeburg; Mrs. W. W. Goodlett of Greenville; Mrs. Kemper Lake of Newberry; Mrs. J. O. Fulenwider, Jr., of Pageland; Mrs. T. P. Valley of Piekens; Mrs. Weston Cooke of Columbia; Mrs. Ragsdale Hewitt of Sumter; Mrs. Jack Bell of Greenwood; and Mrs. W. W. Fennell, Jr., of Rock Hill.

State committee chairmen came from various sections of the state and included Mrs. J. W. Kitchen of Liberty, National Bulletin chairman; Mrs. Neil C. Price, convention; Mrs. C. P. Corn of Greenville, Doctors; Mrs. J. L. Sanders of Greenville, Finance; Mrs. Alton Brown of Rock Hill, Memorial Fund for Student Nurses; Mrs. Kilgo Webb of Greenville,

Legislation; Mrs. James H. Gressette, publicity and press; Mrs. A. W. Welling of Newberry Public Relations; Mrs. P. J. Boatwright of Orangeburg, Printing; Mrs. Newton C. Brackett, of Piekens, Research and Romance of Medicine; Mrs. W. H. Folk of Spartanburg, Revision; and Mrs. John Cuttino of Charleston, Today's Health.

The meeting was called to order by the presiding officer and the president-elect, Mrs. David A. Wilson led the members in the Auxiliary pledge. Routine business included the reading of the minutes, the roll call and reports of officers and county officers. After that Mrs. Whetsell called for nominations for the members of the nominating committee and the following were elected to serve: Mrs. Kirby D. Shealy, Mrs. J. A. Seigling, and Mrs. R. M. Pollitzer. After old and new business were taken under consideration the meeting adjourned to the Eutaw Hotel for lunch. A telephone pad and pencil set was the favor at each place and place cards were decorated with one-winged eoduecus, the emblem of the auxiliary, and an amusing verse.

The invocation was given by Mrs. C. P. Corn and following the lunch, Mrs. Whetsell introduced the visitors at the speakers' table and the guest speaker for the luncheon, Dr. L. P. Thackston, president of the S. C. Medical Association. Dr. Thackston spoke in a very interesting manner of the Auxiliary's place beside the Medical Association. He expressed the doctors' appreciation of their services in the past and asked for their continued support in the future.

Other members of the Advisory Council present were Dr. A. B. Preacher of Allendale and Mr. M. L. Meadors of Florence.

SOUTH CAROLINA WOMEN MEMBERS OF EXECUTIVE BOARD OF AUXILIARY TO SOUTHERN MEDICAL ASSOCIATION

Mrs. J. L. Sanders of Greenville is Councilor from South Carolina and Mrs. M. J. Boggs of Abbeville is Vice-Councilor.

Mrs. C. P. Corn of Greenville is Chairman of Research and Romance of Medicine.

COLUMBIA ENJOYS SOCIAL MEETING

The Columbia Medical Society, assisted by the Woman's Auxiliary to the Columbia Medical Society, entertained with a barbecue in honor of the Medical Society president, Dr. W. P. Beckman, at Heisie's

Pond on October 30. Dr. Tucker Weston and Mrs. Izard Josey served as co-chairmen.

SELF MEMORIAL HOSPITAL SCIENTIFIC SESSION INCLUDES PLANS FOR VISITING WIVES

The wives of the staff of the Self Memorial Hospital are assisting with the plans for the Scientific Session to be held on November 12. Mrs. Jack Bell, president of the Third District, has appointed a committee to take care of the arrangements for the day. Doctors from the state are invited to come and bring their wives.

THE TEN POINT PROGRAM

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

OUR BLUE SHIELD FEE SCHEDULE

This is the first of a series of short articles dealing with the South Carolina Medical Care Plan. This will deal with the new fee schedule which became effective on August 1. This new schedule of fees is more explicit and detailed than the old schedule. Most operative procedures are listed and a specific fee set. If an injury or operation is not listed, usually a comparable one is listed. There are much fewer I. C. (individual consideration) cases.

Although the schedule was prepared with great care and was carefully proofread, some errors crept in. Several of these will be mentioned so that changes may be noted in your copy of the schedule.

Add the following:

0007—Crucial incisions for snake bite, \$20.00.

0043—Removal of foreign body (splinter, needle, etc.) from subcutaneous tissue, \$5-20.00.

0654—Neck traction by halter, \$10.00.

1396—Transurethral fulguration of cysts of vesicle neck or excessive granulation tissue in posterior urethra, \$25.00.

2202—Add the word "unilateral."

2203—Bilateral, \$150.00.

6050—Surgical first aid, prior to referral to specialist for definitive treatment, \$5.00.

6051—Consultation when indicated and not otherwise provided for, \$10.00.

After 0055—Biopsy of breast, add "(by aspiration, \$5.00) independent procedure, \$25.00."

After 0914—add the words, "independent procedure."

Change the fees listed as follows:

1520 to \$50.00.

1546 to \$125.00 (also strike out the words in the second line.)

1585 to \$85.00.

1587 to \$85.00.

2291 to \$15.00.

2292 to \$10.00.

A comparison of the new schedule with the old will reveal that there has been a considerable increase in the fee allowed for many operations. This reflects a successful operation, actuarially. There have also been increased benefits to the subscriber. These changes will necessarily be reflected in lessened additions to our reserves, percentage-wise. However, our constantly increasing enrollment should take care of that safely. At some future date, it is hoped that the maximum fee allowed, which is now \$150.00, may be increased somewhat and that fees which are now substandard may be raised. However, we must feel our way in these matters, and act in accordance with our actuarial experience.

Some of our participating physicians do not seem to understand that only one fee is allowed for multiple but related surgical operations and yet this is clearly stated on page one of the Fee Schedule and is in line with usual operative charges. Probably no surgeon charges an extra fee for routine appendectomy, or for oophorectomy or for puncturing ovarian cysts, when done coincidental with hysterectomy. Nor does he charge an additional fee for breaking up adhesions in the course of a cholecystectomy or gastrectomy. The same is true of repairing a rent in the intestine accidentally made by him. There is no need of stating the lesser and related and coincidental procedures in reporting the chief operation performed. With regard to multiple unrelated surgical operations done by a single surgeon, the general principle is to allow the fee for the major procedure and one-half of the fee for the others. If opinion should differ as to what operations are related and what are not, the decision of the Plan will have to prevail. Some indication of the Plan's attitude is given in the fee schedule by the words "independent procedure" which follow the names of many operations which are done frequently routinely in connection with major operations.

Participating physicians are not only at liberty but are urged to write in complaints, questions, and sug-

gestions. Such will be received kindly and will be replied to as promptly as practical. Mistakes are made in our office and by all of us, although great effort is made to avoid them. At times, delay in settling claims arises because of some unusual feature of the case.

Fees allowed under the new medical and surgical contract for anesthesia can be paid only to participating physicians. However, since in at least one community, nurse anesthetists give anesthetics on a fee for service basis, the Board at its last meeting ruled that the allowed fee in such cases would be paid to the subscriber. This is possible since payment for anesthesia is on a cash indemnity basis rather than on a service basis.

The subject for next month's discussion will deal with the new Physician's Report Blanks.

J. Decherd Guess, M. D.
Medical Director

LEGISLATIVE CONFERENCE FOR CAROLINAS

A Conference on Medical Legislation, for physicians in the two Carolinas, was held in Charlotte on Friday, October 17. The meeting was attended by approximately fifty key physicians from the two states, of which about fifteen were from South Carolina.

This was one of a series of meetings being held in the Southeastern area under the direction of the Legislative Committee of the A.M.A. and the A.M.A.'s Washington Office. Dr. Frank E. Wilson, Director of the Washington Office, and Mr. Jim Forrestal, its legal advisor, were present and discussed matters of interest. Dr. Julian Price of Florence, member of the 9-man A.M.A. Committee for the Southeastern section of the United States, presided.

Needless to say, the meeting was strictly non-political. It was devoted solely to a discussion of the reason for establishment, purpose and activities of the Washington Office; and of proposed legislation affecting the medical profession, directly or indirectly, which was pending at the adjournment of the last Congress, and expected to be reintroduced when the new Congress convenes in January. Similar conferences were held on preceding days in Jacksonville for Georgia and Florida, and in Birmingham for Alabama and Mississippi. The discussion was both informative and interesting. The tone was definitely informal and those attending were invited and urged by the speakers and the presiding officer to ask questions and, generally, to participate in the discussion. This they did.

Included among those attending from South Carolina were three officials of the Woman's Auxiliary to the State Medical Association: Mrs. Alton G. Brown, Mrs. Roderick Macdonald, and Mrs. W. W. Fennell, all of Rock Hill.

Members of the Association present included: Dr. Lawrence Thackston, its president; Dr. O. B. Mayer, Chairman of the Council; Dr. R. L. Crawford, member of Council; and Drs. A. W. Browning, W. L. Pressly, J. O. Warren, Norman Eaddy, W. T. Barron, and W. L. Perry.

All of those attending were the guests of the A.M.A. at luncheon served immediately preceding the business session.

ARE GRIEVANCE COMMITTEES SERVING THEIR PURPOSE?*

Robert E. Fitzgerald, M.D.

It seems to me that the reasons for establishing and maintaining a grievance committee are three in number. First, in compliance with our Hippocratic oath and with our code of ethics as expressed by the American Medical Association, we are bound to make every effort to keep the practice of medicine on the highest possible level. Second, anything we may do in the way of policing our own organization will combat the adverse criticism that has flourished under the New Deal and the proposed Welfare State. Third, a concerted effort to mediate with the public, whenever real or alleged grievances are brought to our attention, constitutes the best type of public relations. It was recommended by the House of Delegates, in December of 1949, that committees be set up to hear, consider, and mediate genuine or fancied grievances, and thirty-four state Medical organizations had set up such committees by September, 1950. These state committees may vary in the number of members, in the tenure of office, in the method of selection of members of the committee, but basically they are all striving for the same goal, namely to demonstrate to the public that, despite adverse publicity disseminated by the proponents of socialized medicine, the medical profession itself has a sincere desire to bring the best service to the greatest number of people. Since in many states the committees are young, they are sailing uncharted seas and each state must deal in its own way with any problems which are peculiarly its own; but all the committees are trying to demonstrate the awareness of the physician to his responsibility to his patient.

A Committee on Grievances, such as we have in Wisconsin, has, in my opinion, certain very definite responsibilities first of which is the responsibility to the public to supply it with the best possible medical care. This responsibility can be fulfilled by seeing to it that the ideals of the profession are upheld completely in the case of everyone practicing medicine: A huge task, no doubt, and one almost impossible to fulfill, but it is worth striving for. Secondly, there is the responsibility to the members of the medical profession itself. This committee examines complaints against the individual physician and, through the

*Reprinted from Minnesota Medicine, April, 1952.

staff at the State Society's office, makes a thorough investigation as to the validity of these claims. When they are apparently valid, the complainant and the physician are given an opportunity to appear before the committee or to communicate with the committee and present their respective sides of the question. These are given deep consideration and, upon reaching a decision, the committee makes its recommendation to the Council of the State Medical Society of Wisconsin which body may recommend to the Board of Medical Examiners that the license of the offending physician be suspended or revoked; or, if in the opinion of the committee, the complaint is not valid or does not hold up under evidence produced by the complainant, the case is dropped and no action is taken by the Council. The Committee on Grievances in Wisconsin has no punitive power, but functions through the Council of the State Society. Another phase of the responsibility of the Committee on Grievances to the medical profession might well be considered educational, since it strives to make all members of the medical profession aware of their own responsibility to the public by observing to the letter and in the spirit all drug laws, by co-operating with the Pharmaceutical association, by working with the Bar Association on the matter of expert testimony in court, and by assisting existing government health agencies.

In discussing the functions of a grievance committee, the question of publicity arises. How much publicity should there be? In Wisconsin, the committee sent letters to judges, to health agencies, and to other organizations interested. In this last category, the Bar Association, which had made some queries concerning expert medical testimony, was especially advised of the formation of the committee and all were acquainted with its aims. To date, no complaints have been received from these groups, but the committee feels that this publicity was beneficial, since it made large groups aware of the existence of the Committee on Grievances and its willingness to work for the public good. In addition, there have been press releases announcing the formation of the committee and its objectives, so that the general public might be informed. The Committee on Grievances in Wisconsin is fully aware of the importance of absolute discretion on the part of its members so that unfavorable, or "gossip" type, publicity can be avoided. Every effort is made to keep all matters confidential, all cases are coded, and correspondence, except with the physician and complainant, is identified by code. It is essential that the existence and objectives of the committee be publicized 100 per cent among the members of the medical profession.

It has been asked, "What is the responsibility of the medical society to the physician who persists in a course of misconduct?" Our committee warns the physician that his case is being reported to the Council and that the Council will recommend a course of action

to the Board of Medical Examiners. Punitive power rests with that Board and the committee can do no more than recommend through the Council. In short, the responsibility to the physician who persists in misconduct merges into the responsibility of the committee to the public.

The Committee on Grievances in Wisconsin does not function as a bill collecting agency. In my opinion, activity of that type would defeat the purposes of the Committee by giving the public the wrong impression of its aims. The only economic phase with which our committee is concerned is that of the fairness of the charges made by the physician, and then only when it is drawn to our attention by a complaint, since we assume that in this day and age any right minded physician realizes the importance of fairness in the matter of bills.

I have selected three typical cases which have come before our committee, in order to give a clearer idea of the Committee on Grievances in action.

Case 1.—A child with a lacerated forehead was taken to a pediatrician during the absence of the family doctor. The pediatrician told the parents that he did not take care of this type of case and referred them to a plastic surgeon. The patient was hospitalized and three pieces of adhesive were used to bring the edges of the wound together. The pediatrician charged \$15 for his advice, the plastic surgeon \$50 for his call and \$5 for each successive treatment. It was decided, after thorough investigation of the case, that treatment by the family physician would not have exceeded \$10. This case is still pending. It is, however, typical of the overcharge claim that is made, although there are many times when a physician is accused by a patient of overcharging when the charge is just and the complaint arises from the patient's lack of knowledge of what the treatment entailed. Physicians have been urged many times to discuss possible charges with their patients before treatment so that there be no misunderstanding.

Right here it might be well to delve a little deeper into the whole question of fees and the necessity of frank discussion of the nature of his condition with the patient. Too often we hear that the doctor gives his patient too little information about the nature of his illness or, if he does make any attempt at explanation, couches this in scientific terms which leave the patient not only in the dark but with a feeling of frustration. It is highly important that the physician take the time to explain as simply as possible what the situation is. He should also point out the cost of treatment and plan with the patient how he may finance his, if it appears to be a burden. In discussion of this sort, frankness is essential. In the matter of fixing charges a doctor should consider several factors: the complexity of the job, the extent of the service

necessary, and the ability of the patient to pay. A certain flexibility in adjusting his fees is often necessary when the patient's financial status makes average charges a burden. When the family doctor feels the services of a specialist are indicated he should explain this to the patient and also give him some idea of the probable charges of the specialist. In this way, many misunderstandings can be avoided and the patient will have a kindlier feeling toward the physician he knows has his best interests at heart.

Case 2.—A physician was charged by a score of people of being intoxicated while attending patients. The doctor appeared before the committee and investigation disclosed that he was suffering from multiple sclerosis and there was no indication of alcoholism. He was advised to stop the practice of medicine for the good of all concerned.

Case 3.—A general practitioner was accused of practices contrary to medical ethics and against the public interest. After appearing before the committee he was advised to consult a psychiatrist, who recommended that the physician enter an institution for treatment.

In addition, there are cases which are brought forward where there is evidence of promiscuous prescription of narcotics to addicts and others. This is often unintentional, but the committee stresses the importance of thorough investigation before prescribing narcotics and places the responsibility on the physician if this is not done.

Conclusion

In my opinion, the Committee on Grievances or the Grievance Committee, if you will, is the best instrument for implementing good public relations that organized medicine has at hand. It can do more for the physician than any other single committee within the Medical Society. Intelligent handling of medical-social and medical-economic affairs, accompanied by intelligent publicity, can do a very great deal to win and retain the confidence and esteem of the public. In its fair dealing, it bridges the gap formed by the natural reluctance of the patient to discuss his difficulties directly with his doctor and acts as a mediating board when differences arise. Members of the committee should be understanding, alert to the problems of the public and the physician, and they should be ever conscious of the paramount importance of discretion.

Since our committee has no punitive power, per se, it must rely upon the complete co-operation of every individual physician for its effectiveness. The fact that this committee, by its recommendations, may set in motion action which could result in suspension or revocation of a doctor's license, should act as a deterrent to that very small minority who might injure the reputation of the great numbers of conscientious mem-

bers of the medical profession. In regard to the minority mentioned, we have in Wisconsin about 3,500 physicians, 3,000 of whom are in active practice. Each doctor sees at least one patient a day which would mean that at least 90,000 patients are treated in a month. The number of complaints which we have received is so small that the percentage of dissatisfied patients is infinitesimal, although it is conceded that that minute percentage can be very noisy on occasion, and, no matter how small it may be, the publicity accruing to one instance of poor or unethical medical practice makes it imperative that any committee on grievances must exert every effort to solve any question that comes before it to the satisfaction of those concerned.

Grievance Committees that function ethically and effectively will be a great factor in avoiding the political control of medicine and, in addition, they can and do protect the economic and professional status and freedom of the physician, by acting at all times in the best interests of the public. Only by proving to the people at large that our Hippocratic Oath is a living thing to us and that the desire to serve mankind, which prompted us to make up the practice of medicine, still motivates our lives can we combat the criticism which has been hurled at organized, free medicine by advocates of the Welfare State.

MOUNTING COSTS OF MEDICAL EDUCATION

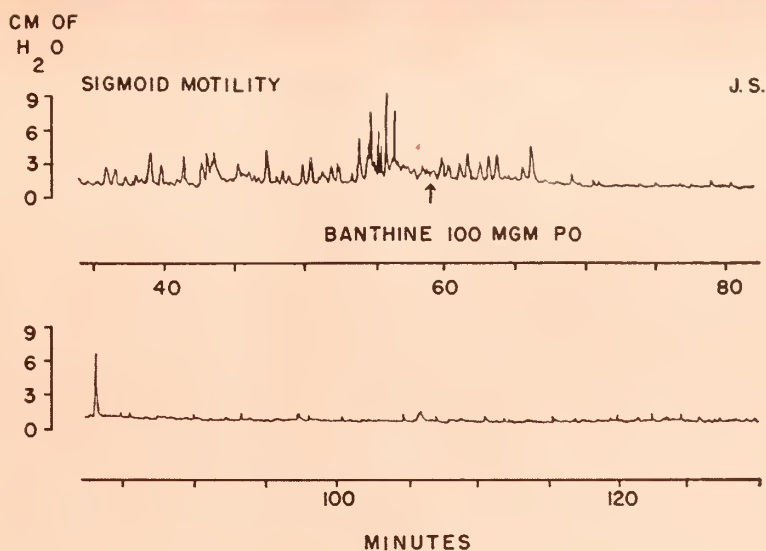
The continuing appeals of the American Medical Education Foundation to the medical profession to raise funds for the hard-pressed medical schools emphasize, to physicians at least, the mounting costs of medical education. There is real worry that education for the practice of medicine may become—as it was in the early years of this century—a "rich man's profession."

A bit of history may be helpful.

From 1900 to about 1914 medical education in the United States was sharply divided into two parts. There were a few good medical schools in the major universities that turned out graduates who very frequently went on for post-graduate training in the European universities. Vienna and Berlin were two outstanding Medical Meccas of the period. But all this took money and only the wealthier student could afford this extended foreign education.

There were also, in this same period, scores of sub-standard medical schools, some no better than diploma mills, where one could obtain a medical degree (for whatever it was worth) without the expense of the larger education with its overtones of PG training in Europe.

The diploma mills, and the poorly-trained men they created, were a menace to the health of the nation.



The effect of 100 mg. of Banthine on sigmoid motility. The contractions did not return during the experimental period.¹

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*The duration of its action is striking,"*¹

It has also been observed that definite retardation in gastrointestinal transit time in individuals with hypermotility was attributable to the therapeutic effect of Banthine.²

BANTHINE® Bromide (brand of methantheline bromide)—a true anticholinergic—is available for oral and parenteral use.



1. Kern, F., Jr.; Almy, T. P., and Stolk, N. J.: Effects of Certain Antispasmodic Drugs on the Intact Human Colon, with Special Reference to Banthine (β -Diethylaminoethyl Xanthene-9-Carboxylate Methobromide), *Am. J. Med.* 11:67 (July) 1951.

2. Lepore, M. J.; Golden, R., and Flood, C. A.: Oral Banthine, an Effective Depressor of Gastrointestinal Motility, *Gastroenterology* 17:551 (April) 1951.

Thus the American Medical Association led the drive to close down the sub-standard medical schools. Through A.M.A. pressure the Carnegie Foundation financed the exhaustive study of Dr. Simon Flexner which made notable recommendations on how medical schools should be staffed and the basic training they should provide.

At the same time the various Specialty Boards came into being (the Board of Ophthalmology was the first in the year 1916) and the standards went up even higher. All in all a young man who wanted to enter medicine and go on for post-graduate training in a specialty had to have major financial resources to carry him over the years until, finally, he could enter private practice and attempt to earn a living.

Sizeable help in this financing came from the endowment funds of the major medical schools and the large voluntary teaching hospitals affiliated with them. The student paid a token tuition that did not pay for more than 25 per cent of his medical education. Endowment funds given to the medical schools as gifts from wealthy individuals and foundations paid the rest.

But rising costs and especially the inflation of the years following World War II have dried up sources of private wealth. New endowments of major size are almost non-existent and the existing endowment funds of universities buy only half what they did before. Thus, more and more, the medical schools have had to raise tuition and make the prospective medical student pay a higher share of the total cost. Again it takes a wealthy student, or a boy from a well-fixed family, to contemplate a medical education.

What can be done about it? The Washington Bureau of the A.M.A. calls attention to proposals that the Federal Government establish scholarships to help the individual finance his medical training. Scholarships would continue at \$800 a year for four years to those who could qualify and can give proof of need. All direct scholarships would end after four years but the holder of the scholarship would be eligible to apply for a loan at \$600 a year for another four years. Repayment of the \$2,400 loan would start four years after the last loan and be paid in full within ten years.

Basic step in the plan would be for the Federal Department of Education to grant to high school graduates "certificates of scholarship" to those with high academic grades. From this list the neediest students would be selected for actual grants and the remainder would receive the certificates as a mark of scholastic honor, though they could not qualify on the basis of need.

What action Congress may take on this proposal when it assembles in January is uncertain. The costs may be one stumbling block.

Here are estimated expenses under the plan:

\$ 32 million—first year
\$ 64 million—second year
\$ 96 million—third year
\$128 million—fourth and subsequent years.

Whether the Federal government or private, individual enterprise should make the grants and thus exert control is a matter of concern to all who see the widening scope of the centralized Federal government and its implications.

That is why every physician should actively support the American Medical Education Foundation in its work of raising money for medical education. If individual effort fails big government is all too ready, as in the past, to step in and take over. If you have not already made your gift to the American Medical Education Foundation do so today through your county medical society.

ACCIDENT AND HEALTH INSURANCE

Each year the Health Insurance Council makes an annual survey* of the accident and health insurance coverage in the United States. This council consists of nine associations in the insurance business, which in turn are made up of companies writing health coverages. The report is intended to provide information for medical groups and hospital administrations about health and accident insurance and this particular report provided figures of interest to physicians.

Up to the late 1930's most health and accident insurance was of the weekly indemnity type. Hospital insurance got its impetus about twenty years ago from the organization of the Blue Cross, and the growth of hospital insurance the past ten years has been phenomenal. Voluntary hospital insurance last year covered 86 million persons. It is perhaps not generally appreciated that insurance companies, by means of group and individual policies, provide for 44 million or over half of this total, whereas Blue Cross and plans sponsored by medical societies cover about 41 million.

Insurance against surgical care got a later start than hospital insurance. Nevertheless the growth of this type of insurance has been just as phenomenal, until today about 65 million individuals are protected against the need for surgical care. Group and individual policies carried by insurance companies total 42 million whereas Blue Shield protects about 24 million against this hazard.

Insurance against medical expenses has been more difficult to institute. Many insurance companies and organizations sponsored by individual societies have

*Accident and Health Coverage in the United States as of December, 1951. The Health Insurance Council, 488 Madison Ave., New York 22, New York.

lost heavily by carrying this type of insurance. Restricted policies, however, are available, and about 12 million individuals are now protected by private companies and 14 million by blue Shield. The total of 27,723,000 now covered represents a 28 per cent increase over the 21,589,000 covered at the end of the year 1950.

These figures all refer to voluntary hospital, surgical and medical care insurance. In addition, 39,702,000 of the 61,000,000 employed civilians are protected by voluntary insurance against loss of income due to disability. This protection is largely for off-the-job protection and three-fourths of it is written by insurance companies. Workman's Compensation cares for most of the on-the-job income loss.

To illustrate the growth of voluntary health and accident insurance, some 9 million additional individuals were added in 1951 to the list of those protected by hospital insurance; about 9 million to those carrying surgical risk insurance; and 6 million to those

carrying medical care insurance.

From these figures are omitted those covered by Workmen's Compensation laws; total and permanent disability benefits included in many life insurance policies; 4,800,000 commercial accident policies providing disability indemnity for injuries; 9,500,000 group accidental death and dismemberment insurance policies; commercial accident policies covering travel hazards numbering 8,000,000; complete medical care for the armed forces and persons in public institutions, and medical care and pensions for war veterans.

It would seem that the American people are health-insurance-minded, have realized the advisability and almost necessity of carrying insurance against the cost of sickness and accidents, and prefer to carry their own insurance instead of adopting compulsory government insurance. It will be most interesting to observe the growth of this type of insurance in the future years and just what percentage of the population ultimately will be covered.

NEW COMMISSION ON HOSPITALS

Ceremonies marking the end of a 35 year period in which the American College of Surgeons held sole responsibility for setting standards for the nation's hospitals will be held Saturday, December 6, when the plan will be transferred to the new Joint Commission on Accreditation of Hospitals in a program at the John B. Murphy Auditorium, 50 East Erie Street, Chicago, at 4 p. m.

Principal speaker will be Senator Lister B. Hill of Alabama, co-sponsor of the Hill-Burton Act, instrumental in constructing over 1000 hospitals especially in rural communities. Dr. Evarts A. Graham, chairman of the Board of Regents of the College, will turn the new program over to Dr. Gunnar Gundersen, first Chairman of the Commission. His Eminence, Cardinal Stritch, will deliver the Invocation.

From now on the American College of Physicians, American College of Surgeons, American Hospital Association, American Medical Association, and Canadian Medical Association will share responsibilities of the program. Proposal for the formation of the Commission was initiated by the College in the recognition that not only surgeons but other members of organizations concerned with medical care in hospitals should participate in the establishment and enforcement of hospital standards. This combination of organizations constitutes an important milestone in

the development of health services for the American people.

Since the American College of Surgeons began its survey of hospitals in 1917, it has spent approximately two million dollars from dues paid by its Fellows for the operation of a hospital inspection and approval system. Its contribution to the improvement of the quality of medical service in American hospitals is generally recognized.

Of this strengthened and expanded program Dr. Gundersen says, "It is a voluntary movement, representing the best thinking and the best inspiration of five of the most powerful groups in the world dealing with health. We recognize what this will mean to the care of the sick and the injured, of Canada and the United States. We realize that this may eventually mean much to the care of the sick and the injured the world over. If the duties are discharged well, the benefits through our profession, through our hospitals, and for our civilization are unreckonable."

Effectiveness of the program of grading hospitals can be seen from these impressive figures: in 1918 out of 692 hospitals surveyed only 83 (12.9%) were approved. Out of 4,111 hospitals surveyed by 1951, 3,352 were approved (81.5%).

Headquarters for the new Joint Commission on Accreditation of Hospitals are at 660 North Rush Street, Chicago 11, Illinois. Dr. Edwin L. Crosby, former Director of Johns Hopkins Hospital in Baltimore, is Executive Director of the Commission.

**TEN POINT PROGRAM
OF THE
SOUTH CAROLINA MEDICAL ASSOCIATION**

1. Cooperation

To promote closer cooperation and better understanding between all agencies, groups and individuals concerned with providing and improving medical care for the people of South Carolina.

2. Extension of Medical Care

To study constantly the need and availability of medical care in each county of the State and in the State at large.

To promote plans for providing or improving medical care where is a need, particularly in the rural areas.

3. Pre-Paid Hospital and Medical Care

To make voluntary pre-paid hospital and sickness insurance available to all the people of the State (through Blue Cross, Blue Shield, and commercial insurance policies), and to promote the widespread purchase of such insurance.

4. Care of Indigent

To work with local county and state agencies, and with philanthropic organizations, toward securing good medical care for the indigent.

5. Public Health

To support the South Carolina State Board of Health in its broad program of preventing diseases and of safeguarding the health of our people.

6. Health Councils

To support the State Health Council in its announced program. To sponsor

the formation of a County Health Council in every county of the state, and to encourage our members to support and to work with these organizations.

7. Hospitals

To promote the expansion of present hospital facilities and the building of new hospitals—where there is a definite need.

To strive for highest standards of professional care in the hospitals in the State.

8. Medical Colleges

To support the Medical College of the State of South Carolina and to bend our efforts toward keeping its standards of education on a par with other medical colleges throughout the country.

To promote good nursing education and good nursing care throughout the State.

9. Education of the Public

To acquaint the citizens of the State with regard to the problems of medical care in existence today, to inform them as to what is being done to solve these problems, and to advise with them as to further plans for securing better health and better medical care for the people of South Carolina.

10. Political Medicine

To prevent political control or domination of medical practice or of medical education.

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Hemorrhagic Nephritis In The Newborn

A REPORT OF 2 CASES

GEORGE DEAN JOHNSON, M. D.

SAMUEL E. ELMORE, JR., M. D.

FRED F. ADAMS, JR., M. D.

Spartanburg, S. C.

Hemorrhagic nephritis in the newborn is an unusual disease. Rennin¹ in 1934 reported 10 cases under 18 months of age which represented 5.5% of all cases of acute nephritis under 13 years of age. None of these was under 3 months of age. Seven were fatal. The author was struck by the persistence of edema, heavy albuminuria with subsequent low protein, and high fatality rate. These features are borne out in the 2 cases reported here.

The earliest previous case was one reported by Karsner² in 1908. This baby was born to an unmarried mother and died a few minutes after birth. The author felt that perhaps the baby's kidneys were damaged by some drug the mother may have taken to induce abortion, though she denied it, and he was not able to find any further evidence of poisoning in the infant. He cites a case report by Ashby³ of a true case of nephritis. La Page⁴ reported another case in 1932. His patient was admitted to the hospital on the 11th day of life and died on the 15th. Conrad⁵ in 1938 reported 3 cases in the neonatal period. Prenatal history was normal in all three. Montagne and Quintana⁶ reported a case in 1942. Their case died on the 11th day of life. The mother died of tuberculosis on the 5th day after delivery. Baby had edema and bloody urine, but no anuria. Yampolsky and Mullins⁷ reported, in 1945, a case of glomerulonephritis in an infant with congenital syphilis. Thompson⁸ in 1951 reported a case that died at 10 days of age. This infant was the third child and weighed 6 pounds at birth. The mother gave a history of having had a mild sore throat at 6 months gestation which responded to sulfonamide therapy. Mother thought left eye of infant was puffy on the 5th day of life. Vomiting began on 7th day and some edema appeared. The mother's second baby died at 1 month of age with edema and cyanosis. In the third baby, at autopsy, the kidneys showed partial or complete hyalinization of the glomeruli. The author suggests intrauterine sensitization to organisms as the possible mechanism of pathogenesis.

The following are the case reports:

Case 1. J. W.

History of case: Born 5-3-49. Infant quite tense after birth. Held head back, neck a little stiff, no fever. Vomited projectily several days. Became cyanotic out of oxygen. By the fifth day of life infant was out of oxygen, no longer vomiting, and was gaining weight. Neck stiff only when he cried.

Age 7 weeks when admitted to the Spartanburg General Hospital. Mother 30, father 37, both in good health. 1 stillborn child 3 years previously. 1 adopted child 11 months of age.

6 pounds 14 ounces at birth. Developed edema of feet and face while in hospital after birth. Passed bloody urine several times after he went home. Was sent to Duke University Hospital where infant showed a normal intravenous pyelogram and the diagnosis of nephritis was made. Edema had about disappeared when he returned home, 10 days prior to admission. 5 days prior to admission he developed diarrhea. 2 days before he began to vomit. Both became worse. No fever, cough, or cold. Had been on simlac and recently on skim milk.

In retrospect the mother remembered having a low grade unexplained fever about 10 days prior to delivery.

Physical examination showed ascites and umbilical hernia. Fontanel sunken, legs and feet only slightly edematous. Throat a little red.

From the time of his admission, 6-17-49, until his death, 8-11-49, his urine was never free of albumen and frequently showed sugar and red blood cells. Fever was present off and on. He had chloromycetin and penicillin as well as digitalis. Frequent transfusions were helpful temporarily. At one point total proteins were 2.7 gm per cent. Edema and ascites varied. Toward the last the abdomen was tapped several times to allow the child to breathe better. He usually ate well and appeared happier and more comfortable after he had eaten. Wasserman negative on mother and child.

(Presented before S. C. Pediatric Society, Columbia, S. C., Sept. 9, 1952)

Weight varied 2 to 8 ounces a day and rose from 5 pounds 12 ounces on admission to 11 pounds 1 ounce at one time. At death it was 8 pounds.

Pathological report showed all the tissues essentially normal except for tubular degeneration of both kidneys.

Case 2:

Admitted 3-14-51. Age 3½ months. 5 pounds 4½ ounces at birth. Normal delivery. Slightly cyanotic at birth. Mother had normal gestation. At about 3 weeks of age mother noted swelling of baby's face and stomach. In a few days the legs were swollen. A doctor in the neighborhood saw the child and made a diagnosis of glomerulonephritis. Has had swelling off and on since. Had a transfusion 1-28-51. Had been on evaporated milk formula with egg white, vitamins, and iron. Had been very uncomfortable and restless.

Physical Examination: Very edematous, pale infant, abdomen greatly distended. Right inguinal hernia.

Extremities: Marked edema.

Course in Hospital: Urine showed albumen from 40 mgm to usually 100 mgm., very few red cells. Hemoglobin was 7.5 gms and the baby was given a transfusion. Intravenous urograms normal. Temperature varied 2 to 3 degrees, usually below normal. Cortisone was tried without success. Infant expired 3-23-51. Wasserman negative.

Pathological report of kidneys as follows: "Kidneys revealed marked congestion of the glomeruli with increased content. The cellular content presents infiltrated neutrophils in the glomeruli tuft. There is also apparent reduplication of the endothelial cells and possibly also of the epithelial cells but apparently more of the endothelial cells. The reduplication of the endothelial cells extends into the afferent artery. There are red blood cells in some of the collecting tubules. This apparently is a type of acute hemorrhagic nephritis in a tiny infant. There is an occasional glomerulus that is becoming fibrosed with fibrosis of the capsule and of the glomeruli tuft. However, in none is there any complete fibrosis as time has not allowed for apparent complete fibrosis of the glomeruli tuft."

Comment: General points in these two cases might be stressed to advantage. Despite the fact that glomerulonephritis in a child usually has a good prognosis in a small infant the outlook is poor. Edema, which usually in an older child disappears after a few days, persists. In the first case, the prenatal history revealed that the mother had a mild fever about 10 days prior to delivery. It is possible that the mother had an infection to which the fetus became sensitized. In the second case, no such history was obtainable.

The mother was normal throughout gestation. This fact does not obviate the plausible sensitization theory or idea because often older children develop nephritis without any recognizable preceeding or predisposing illness. Treatment was futile. Small blood transfusions and a salt free milk seemed helpful but not curative. Cortisone in the second child did not appear to alter the course of the illness one way or the other.

Differential Diagnosis: To make the unusual diagnosis in infancy of acute nephritis an intravenous urogram is necessary. This test eliminates any intrarenal tumor or obstruction that might be causing urinary findings and systemic symptoms similar to those of nephritis. A Wasserman test eliminates the possibility of syphilitic nephritis. The albuminuria, hematuria, edema, low total serum protein all point to nephritis of some type. Renal tuberculosis may simulate nephritis, but the likelihood of overlooking miliary tuberculosis in an infant under 3 months of age is remote.

SUMMARY:

1. Two cases of nephritis in early life are reported.
2. The few important reported cases in the literature are briefly outlined.
3. Comments concerning nephritis in the neonatal period are made with consideration given to all cases reported.

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Prevention Of Prematurity*

FRANK B. C. GEIBEL, M. D.
Columbia, S. C.

It is estimated that altho less than 7% of all births are premature, they contribute more than 65% of all neonatal deaths. The prevention of prematurity would depend entirely upon the recognized causes. Most authorities are agreed in a general way as to what these causes are. 60% are estimated to fall under the classification of unexplained, these are usually initiated by premature rupture of membranes or spontaneous onset of labor without rupture of membranes.

The recognizable causes are:

Multiple Pregnancy	15%
Pre-Eclampsia	10%
Abruptio Placenta	7%
Placenta Previa	5%
Syphilis	1%
Heart Disease	1%
Foetal & Maternal Abnormalities each	1%

Many authorities have repeatedly emphasized the role of maternal nutrition and fatigue in prematurity. They have clearly shown that strenuous work during pregnancy and particularly during the last trimester increases the number of premature births. They also stress that the incidence of prematurity is lowest with adequate prenatal care and highest with inadequate supervision.

There has been no clear cut agreement on the role of nutrition of prematurity. Most authorities agree that it plays a very definite role. Dr. Lester A. Wilson, is reputed to have said "Give me the money to properly feed them and I'll stop them!" Perhaps I could open and close this paper with this sole remark.

What then can we do to prevent premature births? Obviously the answer is our old friend "Adequate Prenatal Care." Prenatal care includes judgment in the handling of obstetrical and medical complications. Keen observation of the patient with anticipatory control of her diet, activities, emotional stability and general health is of course paramount. This, however, is not enough. I believe our prevention should precede even prenatal care, it should be pre-pregnancy or even pre-marital.

If in our pre-marital examinations we should search for and correct nutritional deficiencies, anemias, endocrine insufficiencies and the like, we might be getting nearer an answer to the observed frequencies of premature births in the first born infants and infants of young mothers. The Department of Public Health is concerned in this and is doing much to correct the bad habits of dietary inadequacies. It should begin with the children in the malnourished or economically insecure part of our population. Education along these lines is needed and at last is being given. Here, I believe, will be the final answer to the "unexplained"

numbers of premature births. It will come as it has in other areas of our country, with a raising of the standards of living for all. Why not correction before conception?

It is hard to conceive how we can materially change the figures represented by spontaneous onset of premature labor with or without rupture of membranes. I believe the answer for these "unexplained" causes of prematurity must lie in the above precautions. Prematurity was reduced to a third of its former rate at the Maternity Center Association in New York, by means of extensive and systematic prenatal care.

Prenatal care should include an indoctrination of the patient in the fact that, altho pregnancy may be considered normal, it does alter her physiology. Her activities should be defined. Competitive sports should be postponed during the duration. Auto trips beyond possibly 50 miles should be advised against. At best, these activities may be classified as "calculated risks." Walking is good, short of fatigue. Rest in the afternoon is advisable and particularly in the last trimester. "Paid Work" should probably be discontinued at mid-term. Heavy household work should be curtailed, at least, in the last trimester. Anemias should be corrected at once and prophylactic administration of Iron, Calcium and Vitamins are generally advised. Thyroid is prescribed rather empirically in hypotensive cases and B.M.R.'s are done when indicated. Cramps and spotting should immediately be reported and the patient given bed rest. The use of Stilbestrol and/or Progesterone I believe are indicated in threatened abortion or premature labor. Much has been said pro and con about hormonal therapy. This varies from the use of Stilbestrol alone, advocated by the Smiths in Boston, the combined use of Stilbestrol and Progesterone by Vaux in Philadelphia to a complete lack of faith in either by others.

Among the remaining complications of pregnancy involved in prematurity are multiple pregnancies, toxemia, cardiac diseases, hemorrhage, and syphilis.

I have never heard or read of any method promulgated for prevention of multiple pregnancy. Here, obviously the question is not one of prevention, but of obstetrical handling, if the neonatal death rate is to be lowered. Sharp curtailment of activity in the last trimester, no auto trips, no exercise except walking, no heavy housework, no coitus will help circumvent the tendency to premature onset of labor. Treatment of hydramnios with X-ray search for abnormalities is routine.

Toxemia of pregnancy is not entirely preventable with our present-day knowledge. Much has been said, with which all of you are familiar. The Smith's again have something to say for Stilbestrol noting a decrease in the incidence of toxemia in patients so treated at the Boston Lying-in Hospital. The incidence of late

(*Presented at annual session, S. C. M. A., May 1952)

toxemia in the treated group was around 2% as opposed to almost 7% in the untreated group. They also noted that the premature infants were usually large and mature beyond their gestational age. Hypertensive toxemias are generally controlled by dietary supervision, rest in bed, sedation, control of edema with restriction of salt and administration of ammonium chloride. It usually permits carrying the foetus to term. Pre-eclampsia and eclampsia are of course in another category. Here, we must not be too eager to induce labor. The first thing is to treat the toxemia. It requires experience and judgment to determine how much is careful waiting and how much is procrastination. In pre-eclampsia, the process can most frequently be slowed down or controlled until the baby reaches viability. Remember the obstetrician has a two-fold mission—"to retain a live mother and obtain a live infant." Eclampsia must be carefully handled recognizing the chances for a live baby are at best reduced. Here, the question is usually not one of whether the pregnancy should be interrupted but one of how—and how soon.

Here might be as good a place as any to mention Caesarean Section. The premature notably does poorly neonatally following sections. Elective Caesarean Sections should be postponed to as near term as practicable. We have all seen surprisingly small and even premature infants delivered by elective section in a supposedly term pregnancy.

The concept of obstetrical management of cardiac patients has changed materially in the last two decades. We now recognize that decompensation has a relatively low incidence up to the sixth month of gestation, rises more rapidly during the 7th and 8th month, and becomes lessened during the last month. The premature infant is particularly susceptible to the effects of decompensation in the mother while the more mature infant is relatively unaffected. Here for both maternal and foetal reasons, it is wise to defer induction of labor, if possible, until maturity is no longer a problem.

In speaking of hemorrhage, we usually think of placenta previa or abruptio placenta in the "prematurity stage." Frequently, on examination, however, the bleeding may be found due to other causes, i.e. cervical erosions and trauma. I believe a careful, gentle, aseptic vaginal examination is relatively harmless and may save much worry and prolonged immobilization of the patient. In placenta previa, expectant treatment, rest in bed in the hospital, sedation and replacement of blood loss has permitted patients to gain valuable days or even weeks to obtain a more mature infant. No rigid dictum can be followed and good judgment is needed. Consultation does much to bolster the physician's morale and stay the wielding of the knife of fear.

Abruptio placenta is well named, perhaps, in that it is usually a most abrupt affair. It usually initiates



Chart #1

the onset of labor and action rather than prevention is usually the only solution. Since abruptio placenta is so often associated with toxemia of pregnancy, perhaps here is a straw of prevention.

Syphilis presents, perhaps, our brightest picture in what can be accomplished in the prevention of prematurity. It is now well recognized that with the routine taking of blood tests and the instituting of antibiotic therapy prenatally, its threat has been almost eliminated. In time it should be completely so.

As for the acute and chronic infectious diseases in the pregnant woman: measles, German measles, chicken pox, mumps, whooping cough, tuberculosis, pneumonia, etc, it has been observed the majority of these maternal diseases seem to exert but a slight influence in increasing the incidence of prematurity.

I refer to you the report by Dr. Herman A. Bundeson, "Progress in Reduction of Needless Neonatal Deaths," J. A. M. A., March 15, 1952. This complete analysis has shown what can be done and what needs to be done. He clearly shows that the only solution is a united effort on the part of all hands in tackling the problem. The county or local health officers, the joint committees on Maternal and Infant Welfare, the obstetricians, the pediatricians, general practitioners, hospital administrators, hospital nursing personnel, nutritional, and social service workers must all combine their efforts and their talents to effect a reduction in the neonatal death rate. This must be an unselfish, unjealous, unafraid, group. They must be prepared to meet this problem with an open mind, accept their share of responsibility and take and give constructive criticism. If this paper in any way may serve to stimulate this cooperation, I shall consider the mission accomplished.

Before summarizing, I should like to present two charts showing the incidence of neonatal mortality in the nation as a whole and in our State in particular. Chart #2 shows graphically the importance of fighting for even one more week in delaying delivery in the premature infant.

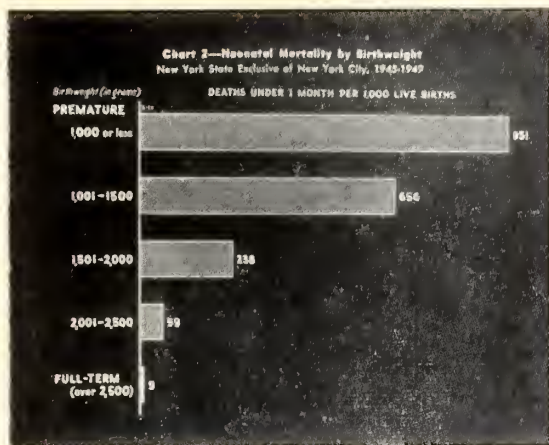


Chart #2

In conclusion then, what positive measures can we adopt that will serve to prevent prematurity?

We can all agree that adequate prenatal supervision has reduced prematurity and certainly the neonatal mortality. Much is yet to be learned regarding the causes of premature labor but the role played by prenatal care and dietary supervision is self evident. The obligation to provide such preventative measures is not only the responsibility of the profession but of the Department of Health as well if the low income or economically insecure group of citizens in our State is to be reached. And it is this group which keeps our incidence in the upper brackets. Restriction of activity and paid work pays dividends particularly in the last trimester. Careful prenatal supervision allows us to catch the toxemias of pregnancy earlier and institute suitable measures to gain maturity for the foetus. This may be the only means of lowering the incidence of Abruptio Placenta. Placenta Previa, on the other hand, except for the very severe cases may be treated expectantly to gain maturity. One must keep in mind, of course, that the mother's life is of utmost importance and great judgment must be exercised. Cardiac cases can most frequently be carried beyond the stage of prematurity before induction of labor is indicated. Syphilis has been practically eliminated as a factor in prematurity by early recognition and treatment. We

may avoid the inexcusable production of prematurity by ill advised timing of elective Caesarean Sections before term. Awaiting the onset of labor is not contraindicated and renders the procedure even easier. The so-called tradition of performing repeat sections two weeks before term should be re-examined. Many recent reports spotlight the futility of selecting a safe time of operating to prevent spontaneous rupture of the uterine scar and there are many incidents of premature infants being delivered at supposedly the 37th or 38th week of gestation. Which is the more hazardous in the long run? As for the spontaneous onset of premature labor with or without the rupture of membranes—I am convinced that I have been able to delay the inevitable delivery for as much as four weeks by judicious use of bed rest, sedation and hormonal therapy.

Finally, the title selected for this paper and the time allotted has not permitted any mention of the all-important role played by the handling of the delivery in premature births. Here the modus operandi of the wise physician becomes the all-important factor in the reduction of the neonatal mortality of the premature infant.

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Shock Therapy In The Agitated Senile

C. J. MILLING, M. D.
Columbia, S. C.

Since the inception of electro-shock therapy efforts have been made to find broader applications for its use.

Because of the remarkable sedative effect of this method it has offered hope of alleviating almost every variety of anxiety, agitation and depression.

The factor of safety has been well established. In 1945 Evans of East Aurora, Ill. treated thirty-eight known cases of serious cardio-vascular disease with not a single fatality. Of these nineteen had evidence of coronary disease, five of whom had a positive history of coronary occlusion. Two others of the series had auricular fibrillation when treated. One of the five with a long standing rheumatic heart was de-compensated at the time of her treatment. Treatment was given to nine patients with systolic pressure over 200. One had had a cerebral hemorrhage.

It is probable, if not certain, that some of Evans' patients would have died of exhaustion had they not been relaxed by shock therapy.

Feeling, therefore, that giving shock to patients in the later decades of life was certainly no greater risk than administering it to cardio-vascular cases, the writer has assumed the responsibility of using this method on a series of elderly people whose distressing mental symptoms needed some measure for their relief.

All of us are familiar with the pathetic picture of the unhappy old man or woman in this condition. In certain types they are so agitated that neither the patient nor the family can get any rest. The patient constantly walks the floor, wishes he were dead and keeps the family up all night. Often an old lady, whose husband is dead, she moves from the home of one married child to that of another, her continued cry being that she knows she is a burden to them all, an insight which is, alas, tragically correct. Or if this is not the symptomatology the patient may be constantly losing his way, unable to identify his home or his own children. In this pitiful condition he is in danger of getting lost or run over by a car or truck. Frightened and disoriented, such a patient calls upon all the tenderness and pity of which we are capable.

We can give sedative drugs, which help for a time but are habit forming and may actually cause a new kind of psychosis engrafted on top of the original picture. Certainly something has to be done.

We, at Waverley, have given electro shock to 50 people of seventy or over. We have had but one dislocation and no fractures in this group, no greater percentage of accident than average. We have had no

fatalities. Of the series not all, technically were suffering from senile psychoses.

(a) Seventeen were diagnosed as true seniles	17
(b) Fifteen as Manic Depressive	15
(c) Ten as Psychosis with Cerebral Arteriosclerosis	10
(d) Four as Involution Melancholia	4
(e) Psychosis with other Somatic Disease	two 2
(f) Psychoneurosis (Hysterical)	two 2
	<hr/> 50

However, they all had the following in common: All were seventy or over; all were either depressed, agitated or excited and could not be relieved by more conservative methods.

The results were gratifying. Of the series all but eight were at least temporarily helped. Nine had more than one series of treatments. Of the eight who received no benefit four failed to return after one or two treatments and were not followed up.

In applying for permission to give shock the family is never encouraged to expect a permanent result. They are told, instead, that while it generally brings relief for the time being, shock therapy cannot restore damaged arteries or deteriorated brain cells. It, can and will, break up a pattern of anxiety and tension at any given time, allowing the patient to secure needed rest. It will prevent a patient from becoming dangerously exhausted.

In such cases we recommend that as few treatments as possible be given at any one time, reserving the method for future needs. Often life can be made bearable for the agitated senile, arteriosclerotic or aged manic-depressive by giving infrequent maintenance doses of shock at irregular intervals. We now have at Waverley five old ladies who get about one shock a month. None of them will ever be better mentally in the sense of being rational or competent human beings, but they all secure relief from tension and are able to live in comparative happiness and security from month to month.

The writer no longer fears to shock people in the later decades. As a rule they have a milder convulsion because of their feeble musculature and actually seem to stand the ordeal better than younger people. While it is not a thing to be undertaken lightly or by untrained, irresponsible personnel, it is the opinion of this observer, the best method at his disposal for relieving the heart-rending anxiety of the aged.

As an example of how the method works in a particular case, I would like to tell you about Mrs. H. B. a senile lady of eighty-six. This old soul, a doctor's

widow and once noted for the elegance of her home and the hospitality she dispensed, had outlived all but one of her children and was an inmate of the Confederate Home in Columbia. She was so disoriented that she was constantly trying to find out where she was and wrote on an average of ten letters or postcards to her daughter every day, begging to go home. She repeated herself constantly and could remember nothing for five minutes. All day and half the night she was walking up and down, wringing her hands and begging for help. The superintendent of the Home

notified her daughter that she would have to be removed. He consented, however, to take her back in thirty days if shock would benefit her sufficiently to justify another trial. After six shocks, which she stood beautifully, she was much quieter and was able to return to the Home. She has been seen at about monthly intervals since her treatment; which took place in December 1950, and is still reasonably cheerful, although, of course, just as disoriented as ever and without improvement to her memory.

The Physician's Responsibility As A Citizen*

HONORABLE WALTER H. JUDD, M. D.

Member of the Congress of the United States from the 5th District
of the State of Minnesota, Minneapolis, Minnesota.

There is not much left for me to tell you. What there is left for me to say will not be worth much more than keeping you here for a few short moments.

I have known Dr. Bunten for a long time and when he tells you to come and speak, you might just as well come and get it over with. Both he and I used to toot horns in a band and both he and I have been tooting them ever since.

I read of a man who was so much troubled by the government interfering in his business about such things as material shortages and the like that he got a bad case of insomnia. He finally went to the doctor and said that he just had to have some rest. He told the doctor that he had counted many sheep and had done all of the other things that he had heard of but that he just could not get any rest. The doctor told him that every medicine that he had was for labor only; to which the man replied, "Isn't there anything for management?"

Medical meetings have changed a lot since the days when I first attended them some thirty years ago. In those days we went to medical meetings primarily to learn how to practice medicine better, to learn the new techniques and the new drugs and new theories. We went in order to try to improve ourselves in the practice of our profession.

Medical meetings have changed because times have changed and our profession is going through some changes in the same way that some of the business men have been going through in the last decade.

Fifty years ago when a man was starting out in a business the first requisite he had to have was that of being a good financier. He had to be able to acquire some capital in order to organize, build and procure some tools and materials in order that he could start production. After he had gotten the capital he had to

organize a production line and know how the material was to be made and how it would look when it came out at the other end. It was not enough that he had to be a Rockefeller or a Vanderbilt—he also had to be a Ford, Firestone or Edison or a Charles Wilson, a production genius. They dominated industry around that period.

At the end of World War I we woke up to the fact that our workers could produce more than there was a developed market for and so a good executive also had to be a good sales engineer. He had to go out and study people and had to be able to create customer demand for his product so that he would have a place to dispose of his products.

Then, along about 1930, there developed a labor movement. Unions came into being and were able to impose many of their demands upon the employers. As a result the executive had to become proficient in labor relations, even though he had plenty of money and plenty of goods to sell.

Now another problem has come up to face the executive and that is that in order for him to know what the government is up to in the way of laws that will affect him, he has to know what is going on in Washington. He has to know what is going on in the various bureaus there and also in his own state capital. He has to have the ability to deal with government as well as all of the other requisites.

As physicians, I think it is important for us to examine the situation in which we live. I believe that every single one of us are taxpayers, parents, citizens and, above all, we are trustees of the noble heritage of freedom.

That heritage of freedom is under attack from the outside and from the inside. You have heard more about the inside phase of it today. They are able to make their headway by changing the nature of our

(*Presented at annual Conference of Presidents and Other Officers of State Medical Associations, Chicago, 1952.)

government here at home and expanding everything that you and I believe in largely because they are able to exploit and determine various situations. You and I know that we could solve every one of these problems of education, health, highways, old age, security and labor management relations; but if we do not handle them better than we have our relations with the rest of the world we will not have much success.

God gave us two wide oceans but with our invention of the steamboat, the airplane and the submarine, we destroyed these two barriers and have now put ourselves into the same boat with the rest of the world. It cannot sink and we stay afloat. Sometimes I wish that we had a planet all by ourselves as we did for the first one hundred fifty years of our existence. Would not that be lovely? However, I know that being Americans, we would not be happy in that state. We would be thinking about some way of getting over into the other planets and starting to do business.

We are not in a world from which we can escape and therefore we have to examine the situation as we examine our sick patients.

A doctor generally does three things with a patient and I think that this is the pattern that we also should follow in our government relations.

The first thing we do is to examine the patient and study and talk with him. We attempt to make a diagnosis so we know with what we are dealing.

If the patient will require extensive treatments and surgery, we first talk it over with his relatives. In politics we talk it over with the voters because they run the machine. We try to convince the patients and relatives as to just exactly what the situation is and what we think should be done.

Finally, if we get their consent, we move in and try to correct the difficulty. We try to remove the malignant process. Sometimes, if it is at the malignant stage, we may have to give them a transfusion or two. If it is an inflammation, we try to bring it down with some wet dressings. You have to use judgment in those matters. At the same time that we are taking all of the corrective action we are looking forward to building good health to replace the diseased part that we are attempting to correct.

I must state that it is wonderful to do these things that we have heard this afternoon. I agree with every one of them. We did most of them in the 80th Congress. We cut down expenditures, we balanced the budget and we cut the taxes. We did that three times and we also paid off some of the debt. I was proud of that—I never was more proud of anything in my life than the 80th Congress because we were saving the American dollar, we were saving our liberty. What happened? Where were you? I was the only representative from a large city from San Francisco to Minneapolis who had participated in that who survived the elections of 1948.

It is easy to get up and cheer these great truths that these gentlemen have been talking about. In the 80th Congress we tried to do some of these things and tried to get our government down to reasonable proportions and I must say that we did make some headway in that matter. However, we got kicked in the teeth for some of our actions and therefore a lot of politicians are going to look twice when you get up and make your pretty speeches and before they vote that way again. Why shouldn't they when you were all out fishing on election day?

I hate to say that but we have a pretty rough time you know. There are a lot of things said about Congressmen and I have a much higher opinion of them now than I had when I went into Washington, believe me. There are a lot more who are hard-working individuals and have guts and go down for their convictions than you ever heard about. I did not know some of them because they are not the fellows who do sensational things or participate in some of the stunts in order to get themselves in the papers. Of course, in the large number of Congressmen that we have, you are bound to find a bunch of misfits and some queer ducks. There are some of these kind of people among the fine group of doctors that we have in this organization also. You will also find them among lawyers, bankers and some of the other professional people. We are the House of Representatives and we represent—we are characteristic.

I believe that we first should examine the threat from without and then just a word or two about the threat from within.

There is in the world today a malignant process—a conspiracy organized and directed from the Kremlin, with well disciplined fifth columnists in every country in the world. These people are bent upon conquest. They live like a malignant process but they are ruthless, relentless and even work on tissues that do not belong.

There is also in this world today the patient who is healthy and has always been that way and who thinks that he can survive anything. Some of those people still refuse to recognize this malignant process that is boring at us from within. It has infiltrated other body politics but he thinks that it will not touch him. He refuses to recognize that that is what it is.

How did the United States move from its all time high of a few years ago to the all time low which we are in this afternoon?

The first reason was one of ignorance—ignorance of the world in which we live. Ignorance of the other people with whom we have to live, whether we like it or not. We did not study European history—I had once had a course in high school and that was all. It was interesting and I studied it to learn about the past. Nobody pointed out to me that the most important thing in my life was to study this history so that I would be able to deal with these people in the future.

We were talking about some of these things in the wastebasket — the things that were tossed away. I think you should read those documents. I believe that you should read the documents of the enemy also for he also has his documents.

How many of you have read the constitution of the World Communist Party? They also have a document. They also have specifications. Its cornerstone is also laid down. What does it say in the preamble of their constitution—is it anything about the establishment of justice? The answer is "No." Does it insure domestic tranquility—no; to form a perfect union—no; securing the process of liberty for ourselves and for posterity—no, indeed. It says, "The objective of this whole movement is to fight for world revolution." That is what it says. That was dated in 1919. It was not the getting rid of a couple of war lords in China. They want a dictatorship. You then ask the question, "Why should these people who have no property want a dictatorship?" The answer is simple — because those with no property have no hope of resisting the state. If you did not have any garden, home or anything else that was yours, would you stand up and oppose the government? That is why our Constitution says that no person shall be deprived of life, liberty or property without due process of law. I do not think that the President has read that recently. The President has now gotten to the point where he says that he has to seize certain industries because it is in the interest of the people. He has said that his oath requires that he do it. His oath is written right in the Constitution. He takes an oath to help him protect, preserve and defend, what—the country? The answer is "No." He takes an oath to help protect, defend and preserve the Constitution of the United States.

The first sentence in the Communist Government Constitution reads, "The form of this government is the People's Democratic Dictatorship." You then look at this and begin to wonder how a dictatorship can be democratic. If you ask them they will tell you that it is for the people and they know what is good for the people. They will tell you that they have to regiment what the people plant and what they sell. They tell you that anybody that does not approve of the government is against the people and they are therefore lined up against the wall and shot. The people that do not agree with the new policies have not learned anything since the Middle Ages.

I do not believe that you can correct our government by writing letters to Congress. I think that the only way to get better results is to change your congressman. You have to get the best people that you can get for Congress. You see, if you want good government from the bottom up you have got to deserve it and work for it.

After the last election I got a letter from a physician at the Mayo Clinic whom I have known for a long

time, in which he said, "You know, just prior to the last election for President we heard so much about the fact that Truman just wouldn't have a chance that we began to feel sorry for him. We thought that he just wouldn't have very many votes at all and we figured that the other candidates would and so a bunch of us decided that we would just give him a vote because we more or less felt sorry for him." These, my friends, were educated and smart people.

Along with the factor of ignorance is the factor of wishful thinking. I am glad that we are the kind of people that we are. It seems as though we do not want anything except to live and let live.

I do not believe, however, that we should try to project our ideas into the minds of the other people of the world and assume that they are going to live by our standards. We have lived according to our code of ethics for such a long time in this country that we have just assumed that they are normal for everybody else. We want the things that we do because we are human and because we have been trained and conditioned to want them.

Those fellows in the Kremlin are human and they want things too, but they are not the same things that we want and so when we hear of what they want, we denounce them. We have taken a lot of things for granted with Stalin. We have felt that he actually wanted to get along with us and so we have leaned over backward in trying to be nice to him. Despite the fact that they could not get along with anybody else in the world, we felt that these people were a peace loving nation and that all they wanted was peace. It was felt that inasmuch as both the Russians and we were fighting Hitler that we were a team and had a lot of things in common. Lately, we have found that the Russians had a few key people in strategic places in our government and they were not exactly helping the cause of freedom along. Most of you will remember Mr. Hiss from the State Department, and the events surrounding him.

You all are aware of the matter of our contributions to these various governments. It is not a question of whether these governments deserve American contributions. The question is whether your boy is deserving of a better chance to live than he will have if these nations are not free and not on our side. The Russians were so interested in seeing that we concentrated our efforts on some of the minor things that we lost almost a third of the world. Some of these people with Communist trained minds were worth a hundred divisions to the Kremlin because by their actions they kept us going in the wrong direction and occupied with secondary things until they had such a hold on us that they could shake us by the throat.

Another factor to consider is the matter of pride. There are some people in the Government that have so much pride that they would rather let our boys

die on the battlefield than admit that they had made some wrong decisions and change the policy. The sacred cow has to be preserved even if the boys and the tanks are not. You just cannot explain some things in any other way.

Recently, at a trade conference, Stalin answered some questions. One of the questions was, "Do you think there is a greater danger of war now than there was ten years ago?" He said, "No." What do you suppose he would say? He was then asked if he thought there would be any benefit from a conference of the Big Four. He just smiled and said, "Probably." He was then asked, "Do you think it is possible for the Soviet Union to exist with the Western Capitalist World?" He said, "Yes, if three conditions were met." The three conditions were: if there was a sincere desire; if there were a meaningful agreement and if neither side would interfere in the affairs of the other. What he merely did was to confirm what was said twenty-five years ago. He wants world conquest and you know that he is not going to abide by any agreement.

They are now making their last stab in Germany and I believe that the Germans have to be smarter than we were or they will fall by the wayside. We are trying to force our virtues into the minds of other people where they do not exist.

That is the kind of a world we are now in and we now come to the question of what we can do about it.

The first thing that we can do is to wake up.

The second thing is to end the notion that the Russian people are a peace-loving nation and that the Communists are Democrats. Those are errors. We should reexamine the patient.

We have got to keep them from further conquest. They are afraid of what we can do to them, not with our troops, but afraid of what our atom bombs can do to their cities. They are also very much afraid of our production capacity. The Russians could strike

the first blow—they could strike into our areas at any time—but they are afraid of American production if we keep our society free. This means that there will be no war until Stalin feels that he can cripple our production effort.

We know that they will not drop any bombs on Washington. Why should they—they do not want to end the confusion there. They will not be ready to start any war until they are ready to deal us some really staggering blows.

This brings me to the last thing—you have to have arms to defeat arms. You can defeat arms with ideas but you have to have very dynamic ideas. History indicated that the only way to win is to keep in motion. A drop of water in motion and constantly dropping on a stone will eventually wear away the stone.

From 1776 to 1931 we were in motion and as a result this country continued to expand in all forms of endeavor. However, with a few exceptions, since that time we have stopped moving and as a result the areas in which men were free began to contract. The Communists are on the move and they are strong because they are united. They are on the offensive. They are awake and alert and we are weak. We are weak because we are static and not united. We now find that we are on the defensive instead of being on the move.

Ladies and Gentlemen, unless we come to a new understanding and have a new birth of freedom in our hearts, we will continue to lose our freedom inch by inch. We have to get on the move and reconquer some of the things that we have lost. Our way of life is based on freedom and we have to have that in order to have hope for the future.

You have been very patient this afternoon and I suggest that if you get a chance that you come down to Washington and visit us and help us to clean up some of this mess we are in.

The Journal of the South Carolina Medical Association

EDITOR: Julian P. Price-----Florence, S. C.

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A CHRISTMAS MEDITATION

The Christmas season is upon us. Store windows are full of attractive wares, shoppers are dashing here and there, carols are being blared from loud-speakers, children are readying their stockings, Christmas cards are being bought and addressed, turkeys are being readied and fruit cakes baked, families are planning reunions, college boys and girls are making arrangements for parties and dances—yes, the outward signs of the Christmas season are upon us.

But what of Christmas itself—what is the real meaning of the occasion, what hope does it hold to a world beset by anxiety and fear?

Was there ever a time when the peoples of the world were in greater need of a true understanding of the spirit of Christmas than today?

A global war is being waged, a war of ideas and principles—and the stake of the entire world hangs in the balance. On the one hand are the forces of godlessness, of might, of hate, of deceit, of ruthlessness. On the other side are the forces of decency, of honesty, of neighborliness, of truth, of righteousness. The one is led by the fanatics of Communism, the other by the believers in Christianity.

It was some two thousand years ago that a babe was born in Bethlehem, and the song which the angels sang at his birth was of "peace on earth, and goodwill among men." They called his name Jesus and he lived for thirty three years in the little country of Palestine. Finally, he was nailed to the cross between two thieves. Yet in that short span of time he set in motion forces and ideas and principles which have rocked the world and which are the only hope against Communism today.

Christmas is the celebration of the birthday of the founder of Christianity. And the true spirit of Christmas is the spirit of Him who "came not to be ministered unto but to minister, and to give his life a ransom for many."

As we join in the festivities of the season we would do well to draw apart from the crowd for a while and to ponder the deep significance and the true meaning of the spirit of Christmas,

FOOD FOR THOUGHT

A letter has been received from a colleague which we wish to share with all the readers of this Journal since it contains much food for serious consideration.

"We have all been concerned about increasing costs of government, public assistance, and medical care.

"There is no doctor I know of who isn't making a good living. There is no doctor I know (including myself) who is overburdened with charity work. Could we not here in South Carolina begin to get away from accepting government funds (totally inadequate as they are in the sense of fee for service) for every little piece of work we do for those in need. Much that we do under the present setup simply bolsters the apparent need for public assistance programs. As willing and perhaps at times even sacrificial workers, we could as a group do much to lower the volume of need now showing on statistical reports. In my opinion they are all padded and lie in the direction of a greater need than actually exists.

"If we could band together, I believe that more constructive measures could be taken to help save the faces and individualities of those needing our help, lower the costs of medical care both to the individual and to those few agencies which are truly essential, retard or stop all the nonsense about socialization of medicine, and enhance if not indeed restore the medical profession to that station of love and respect which was once ours and should be again."

The idea which the writer of this letter advances is novel and yet one which warrants careful consideration. The Editor will welcome comments and opinions from other doctors as to whether they think such a proposal should be put into action.

A NEW DAY AHEAD

With the advent of a Republican administration in January, the American Medical Association and our own Association will find a new type of work waiting to be done. Neither the national organization nor our state association has been a political body, but of necessity we have advocated or opposed basic principles of government as well as specific types of

legislation. Under the leadership of President Truman, the Democratic party sponsored social and socialistic measures which were in direct conflict with our conception of what government should do or should be and we offered strenuous opposition to the program.

General Eisenhower and the Republican party, however, have endorsed principles for which we have been fighting through the years and when these principles are written into specific measures we will find ourselves in the vanguard of the proponents of the legislation.

General Eisenhower has stated repeatedly that he is opposed to national compulsory insurance or socialization in any form, and in this he is supported by the platform of the party. General Eisenhower is determined that every effort be made to support medical education without resort to financial assistance from the government. He is in favor of extension of tax relief to self-employed persons to help them establish pension funds—and for this the A. M. A. has been making its wishes known. He is in favor of organizing and administering medical welfare programs on the community, county, and state levels as much as possible—calling upon the federal government only where financial support is otherwise unavailable. He favors decentralization of power, and is opposed to a bureaucratic type of government.

There are few physicians who will not agree wholeheartedly with the principles listed above, and they will be anxious to aid the General in putting his word into action when he assumes the Presidency. General Eisenhower and his associates will need not only support but advice as they tackle the various problems in the field of medicine and medical care—and it will be the responsibility of the American Medical Association and of state medical associations to render this advice when it is sought.

DEATHS

HUGH B. SENN

Dr. H. B. Senn, 64, Newberry physician and former state health official, died October 6, at a Columbia Hospital after several month's illness.

Dr. Senn received his education at Newberry College and the Medical College of South Carolina (Class of 1918). He had served on the state board of health in South Carolina and Georgia and had been health officer in Beaufort and Newberry Counties.

Surviving Dr. Senn are his widow and two daughters.

JOHN RAYLORD POWERS

Dr. J. R. Powers, 73, beloved physician of Abbeville County for over forty years, died at his home on November 6, after a long period of illness.

A native of Abbeville County, Dr. Powers received his education at the University of Maryland and the Medical College of the State of South Carolina (1912). He was an Honorary Member of the South Carolina Medical Association.

Survivors include his widow, the former Miss Florence Bradford, and one daughter.

DONALD EDWARD MICHIE

Dr. Donald E. Michie, 50, died on October 25 at a hospital in Savannah after several months of illness.

A native of Darlington County, Dr. Michie attended the schools of the county, the College of Charleston and was graduated from the Medical College of South Carolina (1934).

Following his internship, he entered general practice in Bishopville and then in Marion. During World War II, he served for three years with the Army Medical Corps, spending twenty months overseas. He was a Mason and an officer in the Presbyterian Church.

Dr. Michie was loved by those who knew him. His winsome manner, his hearty laugh, his love of the beautiful and his devotion to service made him a physician of whom his community and his colleagues could be justly proud. For those who contend that idealism has gone out of the practice of medicine, Dr. Michie's life presented an argument which proves them wrong.

Dr. Michie is survived by his widow, the former Miss Elsa Schroeder, and two young sons.

NEWS ITEMS

Dr. A. D. Couch has returned to Easley to practice medicine again after serving in the Army for the past two years.

Dr. Joel W. Wyman has returned to Anderson and re-opened his offices for the practice of dermatology.

Dr. Grady Oliver is now associated with Dr. M. J. Boggs of Abbeville in the practice of general medicine.

Dr. N. J. Knoy, army surgeon for the past several years has located in Bamberg.

Dr. Fritz Johnson, general practitioner of Mullins, has received orders to report for active duty with the air force.

Dr. F. E. Kredel, head of the department of surgery at the Medical College of South Carolina, has been presented the Distinguished Service Award by the University of Chicago.

Dr. Wayne Reeser is now associated with Dr. O. R. Russell of Conway in the practice of radiology.

Dr. Dessie Gilland of Conway has been advised to take several months of rest in the Florence-Darlington Tuberculosis Sanitarium.

Dr. Ed. Proctor has recently located in Conway for the practice of General Surgery.



Ulcerations of Large Intestine due to *Endamoeba Histolytica*

Ulceration of the large or small intestine, perforation of the bowel, hepatitis and hepatic abscess are among the serious complications of intestinal infestation with *Endamoeba histolytica*.

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*Hamilton, H. E., and Zavala, D. C.: Amebiasis in Iowa: Diagnosis and Treatment, J. Iowa M. Soc. 42:1 (Jan.) 1952.

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

The Doctors Black, Suzanne and Swift, of Dillon are receiving congratulations on the arrival of a young daughter.

Dr. O. T. Finklea of Florence was recently elected President of the Pee Dee Medical Association for the coming year.

Dr. and Mrs. Douglas Ellis of Florence announce the arrival of a young son.

Dr. Harvey E. McConnell of Lancaster has been awarded a fellowship in the American College of Surgeons.

Dr. W. Burns Jones has been discharged from military duty and has resumed his practice in Beaufort. Dr. Jones served four years during World War II, and has recently spent two additional years with the armed forces, 16 months in Korea.

Dr. and Mrs. Malcolm McKenzie of Greenville, and Dr. and Mrs. Landrum McCarrell of Greenville, are being congratulated upon the arrival of babies in their homes.

Dr. Cecil White of Greenville has passed the examinations and is now a Diplomate of the American Board of Surgery.

Drs. Lucius Cline and Willard Hearin of Greenville have been called to active duty by the Navy.

Dr. W. H. Speisegger of Charleston has been installed as President of the South Carolina Academy of General Practice, succeeding Dr. T. G. Goldsmith of Greenville.

Dr. Francis H. Gay is now associated with Dr. James T. Green of Columbia in the practice of orthopedic surgery.

HEALTH SERVICES ADVISORY COMMITTEE

The Federal Civil Defense Administration has requested the American Medical Association, the American Hospital Association, the American Veterinary Association, the American Dental Association, the American Pharmaceutical Association, the American Nurses Association, and the Association of State and Territorial Health Officers to suggest appropriate members of their respective organizations to form a Health Services Advisory Committee in each of its nine regions.

While the formation of the Committee is not yet complete, the Atlanta office of the Federal Civil Defense Administration, the headquarters of Region III, which comprises the states of Alabama, Georgia, Florida, Mississippi, South Carolina, and Tennessee, has announced the names of those who have indicated they would serve.

They are:

Representing the American Medical Association:
E. M. Dunstan, M. D., Atlanta, Georgia,
Charles Downman, M. D., Atlanta, Georgia.

Representing the American Hospital Association:
Charles W. Flynn, Jackson, Mississippi,
Edwin B. Peel, Atlanta, Georgia.

Representing the American Veterinary Medical Association:
D. A. Sanders, D. V. M., Gainesville, Florida.

Representing the American Dental Association:
H. Harvey Payne, D. D. S., Atlanta, Georgia.

Representing the American Nurses Association:
Mrs. Mildred B. Pryse, R. N., Atlanta, Georgia.

Representing the Association of State and Territorial Health Officers:
R. H. Hutcheson, M. D., Nashville, Tennessee,
T. F. Sellers, M. D., Atlanta, Georgia.

This committee will advise and assist, within its region, in the implementation of policies and instructions formed by the Federal Civil Defense Administration working with the national organizations and federal agencies.

It is not intended to replace, but would complement and strengthen the work of any other groups of state civil defense health and medical services directors.

Dr. John M. Whitney, Medical Officer for Region III, will head the committee. Organization of the committee is under way, however, the number of meetings will be held at a minimum consistent with good progress.

As the meetings will be held in Atlanta, the organizations were requested to nominate representatives in or as close to Atlanta as possible, in order to hold down time and expenses, which explains the predominance of Atlanta residents on the committee.

It should be emphasized that these members represent their respective organizations in everyone of the six states in the region.

CORRESPONDENCE

Dr. Julian P. Price
117 W. Cheves Street
Florence, South Carolina

Dear Dr. Price:

In further reference to our telephone conversation, the South Carolina Heart Association appreciates the publicity given it in the South Carolina Medical Journal.

Our Annual Meeting will be held jointly with the Greenville County Medical Society beginning at 4:30 p. m., February 3, and lasting until 5:00 p. m., February 4. The Meeting is tentatively scheduled at the Nurse's Home, Greenville General Hospital. The principal speakers for this Meeting will be Doctors Robert Grant, Richard Bing, Paul D. White and Dwight Harken, eminent surgeons and cardiologists. All of the doctors of South Carolina have a cordial invitation to attend this Meeting.

We will appreciate it if you will give as much publicity as possible to this Meeting in the Medical Journal.

With kindest personal regards, I am

Very sincerely yours,

H. M. McElveen

Executive Secretary

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THE TEN POINT PROGRAM

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

BLUE SHIELD PHYSICIAN'S REPORT FORM (Second in a Series of Articles)

The new report form is more detailed than was the earlier form. Experience with the simpler form was unsatisfactory in that it was frequently impossible to fix an appropriate fee for the service rendered because information was so meager.

Although the new form may appear complicated, it is really rather simple when broken down into its component parts. There are six such parts, namely a general first part giving identifying and classifying information, a part for reporting surgical service, one for obstetrical cases, one for anesthesia, one for x-ray examinations and one for medical services. Thus, the entire form does not have to be filled out for any one case.

The first three lines of the first section are wholly for identification. Every question asked is needed to establish the identification of the patient treated. Most of the answers are carried on the subscriber's Blue Shield identification card. It is wise to ask for this card at the first interview, so that you will know you are dealing with a Blue Shield subscriber. The subscriber is instructed to show it to the doctor when he presents himself for treatment. If this is insisted upon, misunderstandings will be minimized.

A statement of the patient's family income is requested. This is quite important, and yet doctors seem to find it unpleasant and many of them neglect it. For most patients, the doctor more or less instinctively knows whether or not the family income is more than \$4,000 per year. If there is doubt, it is a simple question to ask and the subscriber will not resent it. He has answered the question on his application. He knows or thinks he knows his rights under his membership contract. The doctor, in asking about the income, indicates to the patient that he wishes to extend to him the benefits of that membership contract.

There have occurred several embarrassing incidents in connection with a failure to indicate the income limits of the patient. The report is filed, the claim is paid, and then comes a complaint from the subscriber stating that he still receives bills for an alleged unpaid balance due the doctor. Rarely, the doctor is within his rights in demanding a greater fee than the schedule allows. There no doubt are subscribers who would deliberately gyp the doctor. Against such patients, whether Blue Shield subscribers or not, the doctor must be on his guard. However, most of the complaints of charges greater than the amount paid by the Plan have been found, upon investigation, to be justified. The doctor is not always personally to blame for the overcharge. Frequently the fault is with his

bookkeeper who is not familiar with either the subscriber's or the participating physician's contract.

It is important that we know whether the patient was treated in the office or clinic or at a hospital and whether as an in or an out patient. It is helpful to know whether or not the patient was referred by another physician. Such a physician might also send in a report, and the two reports should be processed together.

Conditions known to have been present at the time of application for membership are not covered for a period of one year. Therefore, in case of chronic conditions, it is necessary that the time the patient first knew of the trouble be stated. The Plan could be wrecked by members who joined simply to get a needed operation without cost and who lapsed membership shortly after operation. Otherwise honest people do not seem to think that wrong, and our Plan has to depend upon our participating physicians to help guard us against them. Probably anyone of you would be amazed at the number of moles, birthmarks and warts which have been removed from our subscribers and which allegedly either suddenly appeared or suddenly became inflamed or irritated. Their number, in part, explains the low fee paid for their removal.

A word about "Diagnosis." Please do not state the admitting or preliminary diagnosis. State the final or true diagnosis. Occasionally, we receive a diagnosis of "possible ovarian cyst," and yet the surgical procedure reported has no bearing on that diagnosis. Similarly, "appendicitis," without qualifying adjective has been the stated diagnosis, while the major operative procedure reported is some pelvic surgery.

Try to state the code number which you think applies to the operation done. This is important in establishing the fee. As was stated in the article last month, it is unnecessary to report minor coincidental surgery related to the major operation, nor is it necessary to record their code numbers.

The new form requests that you state your regular fee for the services performed. This is requested with no desire to investigate your personal business or your charges. To know what you would charge gives us certain valuable information: namely, whether or not our fees are out of line with reasonable minimum fees, and whether you are, or the subscriber is going to be dissatisfied with the fee allowed. To know this allows us an opportunity to explain the disparity. Finally, to know your usual charge is an aid in fixing a fee for I. C. cases or cases which present unusual difficulties.

The obstetrical portion of the report form is very simple. The type of delivery is important in order to

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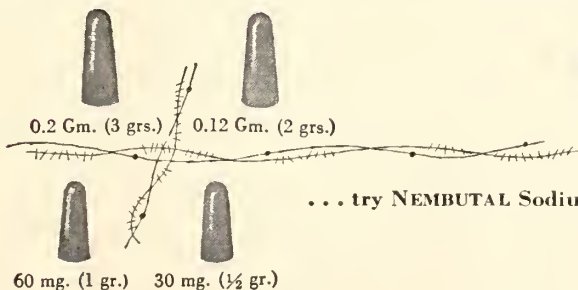
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fix the fee. So is information as to whether or not the case was referred by another physician. If delivery was by forceps, it should be specified whether low, mid or high. For your own protection, bear in mind that the Plan pays for delivery and immediate postnatal care. Unfortunately, difficulties are too great to undertake protection for full obstetrical care at this time. Participating physicians have a perfect right to charge for prenatal care and the postnatal check.

Anesthesia is covered on a cash indemnity basis and only for subscribers having the new surgical and medical contract. Where anesthesia is administered by a nurse anesthetist, the indemnity is paid directly to the subscriber. Where the operating surgeon himself administers local, intravenous or spinal anesthesia, he is allowed no extra fee. Although a maximum fee of \$15 is allowed for anesthesia, that fact does not imply a limitation of the fee to be charged the patient.

Certain limits had to be made in x-ray services. A limit of \$15 per case is allowed, and this for diagnostic purposes in accident and injury cases only. Additional fees for x-ray services in these cases may be charged the patient.

Coverage of medical services applies only to subscribers to the new medical-surgical contract. It is a cash indemnity service, applicable only to hospitalized medical cases and begins on the third hospital day. The indemnity paid does not limit the physician's charges but simply applies on his bill. Of course, he makes his usual charge for the case. The daily cash indemnity may be superseded by the applicable surgical fee, should surgical complications arise.

Many participating physicians have overlooked the reverse side of the first sheet of the report form. The information requested there is most important and is absolutely essential in fixing many fees. To omit filling it out invites correspondence and delay in processing the claim. Please cooperate by filling it in.

The next article will deal with provisions of the subscriber's contract.

J. Decherd Guess, M. D.
Medical Director

MRS. HOBBY TO SUCCEED OSCAR EWING

Perhaps of all the appointments thus far announced by President-elect Eisenhower, none is of more direct and genuine interest to the members of the medical profession than that of Mrs. Oveta Culp Hobby as Federal Security Administrator, to succeed Oscar R. Ewing.

Mrs. Hobby, of course, will be remembered by everyone as the first National Commander of the Women's Army Corps during the recent war. In that position, her executive and administrative ability seems to have been clearly demonstrated and her vibrant and attractive personality was no doubt a distinct asset to the newly formed unit, which for the first time provided a means for participation by women of the United States in the military activities of the country.

In making the appointment, General Eisenhower

indicated that Mrs. Hobby would be invited and expected to attend the meetings of the Cabinet, although her position is not one of Cabinet status. In doing so, the President-elect evidenced his recognition of the vital importance of the Federal Security Administration and its widespread activities in the general economy and welfare of the nation. It is a healthful sign, we believe—this recognition on the part of the new President-elect, in large measure as the result of widespread dissatisfaction with some of the more liberal policies and activities of the previous administration. It seems to indicate the absence of any tendency to direct the policies of the new administration toward the other extreme.

No doubt, the appointment of Mrs. Hobby to this important post will meet with general approval, as have the appointments to the new Cabinet thus far.

REVISED PENSION PLAN FOR SELF-EMPLOYMENT*

If Congress is to be persuaded that self-employed individuals deserve equality of treatment with corporation employees and executives in the opportunity to provide retirement income for themselves, *now is the time to talk with candidates for Congress.*

More than a dozen professional groups, including the American Bar Association, American Dental Association, *American Medical Association*, and the American Institute of Accountants, are cooperating to make sure that every candidate for the United States House of Representatives or the Senate, whether he is an incumbent or not, will be asked between now and November whether he will support the plan for voluntary pension funds embodied in the *Keogh and Reed bills* (H.R. 8390 and 8391). The basic feature of these identical bills, one introduced by a Democrat and the other by a Republican, is that they would allow self-employed individuals, and others not covered by existing pension plans, to defer payment of taxes on income set aside in restricted retirement funds. This would give them an incentive to save for retirement comparable to that which is now enjoyed by corporate employees covered by retirement plans under Section 165(a) of the Federal Internal Revenue Code. The principle of these bills was endorsed by the members of the American Institute at the last annual meeting.

Public hearings on the bills were held by the Ways and Means Committee of the House of Representatives in May. As a result of criticisms and suggestions made during the hearings, the bills have been extensively revised by an interprofessional committee on which the American Institute was represented. The new bills, which were introduced by Representatives Keogh and Reed under the numbers given above, offer a fair and reasonable approach to the problem of allowing self-employed individuals to provide for their old age under today's high tax rates.

The only serious objection to this proposal has been raised by the Treasury Department, which is con-

*The Journal of Accountancy, Editorial, October, 1952.

cerned about the possible loss of revenue, and has proposed as an alternative that Section 165(a) of the Revenue Code should be repealed. However, the Treasury admits that the present situation is inequitable, and since it is unlikely that the Congress would upset the many thousands of corporate pension plans which have been set up under provisions of law adopted in 1942 it is only fair that the self-employed should receive similar benefits. Moreover, encouragement of voluntary provision for retirement is consistent with long-established public policy, and is not likely to be curtailed by Congress. Dr. Frank G. Dickinson, Director of the Bureau of Medical Economic Research of the American Medical Association, has estimated that the immediate loss to the Treasury if the Keogh and Reed bills should be enacted would not exceed 250 million dollars a year, and a considerable part of the loss would eventually be recovered, since the pensions would be taxable when received.

A significant improvement in the revised bills would allow individuals who had reached the age of 55 at the time of enactment to set aside a higher proportion of their income for a period not to exceed 20 years than would be allowed to younger men. At the same time, the revised bills set a limit of 150 thousand dollars on the maximum amount which could be set aside tax free during any individual's whole working life. It has been calculated that even an individual fortunate enough to earn 75 thousand dollars a year or more over a period of 20 years would not be able under this plan to provide a pension of more than about one thousand dollars a month on retirement and the pension funds which could be set up under the plan by the average professional man would of course be very much less than that. Actually, therefore, the maximum benefits available to self-employed professional men under these bills would be considerably less than those enjoyed under Section 165(a) by many corporate executives.

Another important provision of the new bills would allow a carry-over of unused exclusions. This is designed especially for the benefit of individuals, particularly in the entertainment field, with widely fluctuating incomes who are now subjected to high tax rates when their earnings are good.

The issues at stake have already received some political approval. Republican Presidential Candidate Dwight D. Eisenhower told an interprofessional committee in August that he firmly approves the removal of tax-structure discrimination against the self-employed. And according to John W. McCormack, chairman of the Democratic Platform Committee, that party endorses legislation "... to provide voluntary pension systems for the self-employed and professional people."

The fairness and social desirability of these bills should be apparent to anyone who takes the trouble to examine their provisions. *They can be enacted by the next Congress if professional men, who have the greatest stake in them, will take the trouble to explain them*

to candidates for Congress. They need not only general support, but some individual personal effort.

MEDICAL EDUCATION CONTRIBUTIONS DEDUCTIBLE

A letter from Dr. Louis H. Bauer, president of the A. M. A. was mailed a few weeks ago to 150,000 physicians in the United States, calling attention to the need for contributions to the American Medical Education Foundation. Accompanying the mailing was information pointing out that such contributions are deductible in the calculation of income tax for the year in which the contributions are made, and specifically citing the tax savings and the net cost of the maximum gift in a number of instances of varying amounts of aggregate, adjusted incomes.

Every member of the Association should have received such mailing, and it is hoped that many of them gave careful consideration to the contents. The attention of any who may have missed it might well be directed to this matter. It offers an opportunity to those in financial position to do so, to aid a most worthy cause, while at the same time reducing the burden on the individual who makes the contribution, so far as Federal income tax is concerned.

NATIONAL SOCIETY FOR MEDICAL RESEARCH REPORTS

The Sixth Annual Report of the National Society for Medical Research to the Association of American Colleges, released November 10, 1952, states that:

"A study of medical history gives the impression that antivivisection sentiment was a factor medical investigators had to reckon with at least as long as four hundred years ago. Clippings from American and British newspapers reveal that the antivivisection movement was virulent in the 1890's and that it grew into a well organized, politically effective force in succeeding years. By 1945 there were more than 100 distinct antivivisection organizations in the United States and seven states had restrictive laws. The largest publishing organization in the United States was actively supporting the antivivisection cause.

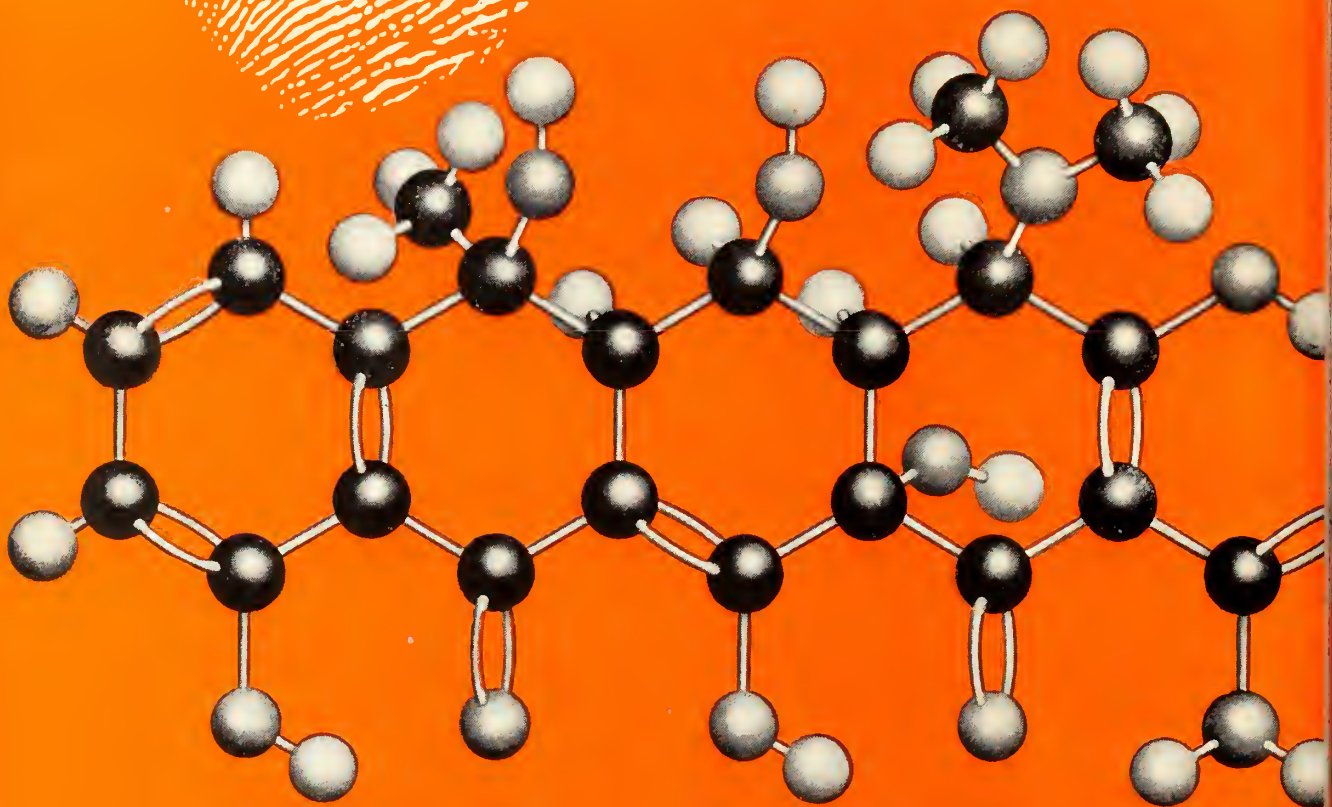
"The trend of four hundred or more years of history has been substantially altered in the six years and five months since the National Society for Medical Research began operations. Any check of public opinion will show that the antivivisectionist cause is largely discredited. Every state law adopted in the past half dozen years has favored medical investigation and has been a defeat for the antivivisectionists. There is no outstandingly powerful champion of the antivivisection cause anywhere in this country today."

The change referred to was attributed to the fact that medical scientists and administrators had made two general changes in policy:

"First, the policy toward public information has been changed so that the public can learn freely about the experimental work which lies behind medical discoveries. Animal experimentation has ceased to be a



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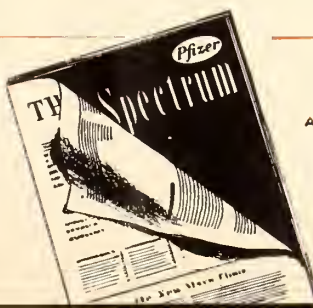
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"Second, medical scientists have taken the initiative in seeking legislation that serves medical science and the health needs of society. The course of public policy is no longer initiated by the opponents of medical science."

Among major developments in 1952, as reported by the Society, are the following:

"New York's Hatch-Metcalf Act is undoubtedly the major legislative development of 1952. The bill, passed by large majorities in both houses of the state legislature, saves for experimental use otherwise doomed dogs and cats in public pounds. Debated, and bitterly, and challenged repeatedly since its passage, the Hatch-Metcalf law is being administered with excellent cooperation by the ASPCA's New York City branch. Governor Dewey praised the bill when he signed it into law, and since then two state supreme court justices have upheld its constitutionality. Hatch-Metcalf provides a source of supply for laboratories doing a large share of the nation's medical research.

"Elsewhere, court actions tested animal procurement laws. In Wisconsin, Elmer Steinhilber, Oshkosh animal supplier, won a decision against one section of the state's animal law. A judge rules that state law could not prevent the shipment of live animals out of state, the offense for which Steinhilber was arrested.

"In Los Angeles, antivivisectionists are still pressing suit as dog owners against that city's pound ordinance. Antivivisectionists have never before won such a decision. In fact, such cases have always been disqualified before trial because no sound legal basis was ever presented in an antivivisectionist complaint.

"General opposition to animal experimentation by the Hearst press stopped this past year. No definite new policy has been announced, but the recent practice of the Hearst papers indicates a new friendliness to medical science.

"While it is true that the change in Hearst policy followed the death of William Randolph Hearst, Sr., the change has also been explained by one Hearst writer as follows: 'antivivisectionism isn't as hot as it used to be. Everybody knows about the new operations and drugs discovered through experiments on animals, and people get pretty hostile about anyone's trying to stop that sort of thing.'

"Whatever the explanation, the change in Hearst policy was made more convenient and more expedient by a growing public awareness of the vital role played by experimental animals in the conquest of disease.

"In December 1951 an organization to honor persons who have served as voluntary subjects for medical experimentation was founded with the backing of the NSMR. Called the Walter Reed Society, the new group elected national officers at its first meeting, held in conjunction with the AMA's Clinical Sessions in Los Angeles. The officers are Dr. Max Sadove, President; Drs. Clinton Thienes, Lloyd Seager and John P. McGovern, Vice Presidents; and Miss Elizabeth Jenny, Secretary-Treasurer.

"The purpose of the society is to give the general public an insight into the role of human subjects in medical research, and to provide recognition for the

contributions of these volunteers.

"The Walter Reed Society now has more than 100 members. Local chapters of the Society have been formed in several medical centers and three new local groups are in formation."

TAFT TO HEAD LABOR-WELFARE COMMITTEE

Senator Taft, announcing he plans to assume chairmanship of the important Labor and Public Welfare Committee, says that in the next Congress he will concentrate on social welfare problems rather than labor legislation. In the Republican-controlled Eightieth Congress Senator Taft also headed this committee, but divided his interest between social legislation and labor, including sponsorship of the Taft-Hartley law. In explaining his attitude, the Senator is quoted as saying:

"This time my interest is more in the public welfare end of the committee's work than in the labor end. General Eisenhower has spoken of expanding the social welfare program, and I am interested in seeing that the new legislation takes the proper course."

The Labor and Welfare Committee has handled a majority of bills important to medicine, including compulsory health insurance, aid to medical education, aid to local public health departments, drug prescriptions and some veterans bills.

PRESIDENT'S HEALTH COMMISSION STUDYING MATERIAL

With all sections of the report now "blocked out," the Magnuson Commission and its staff currently are at work on the first volume, which will contain all major recommendations and some supporting material. This section is expected to be ready for the President by the December 28 deadline, although there may be some delay in getting the other four volumes together, according to a Commission spokesman.

The Commission now is concentrating on the most critical part of its year-long task—a final screening of factual material and recommendations for the all-important first volume, the one expected to receive most public attention. Other volumes, containing statistical material and more detailed presentation, will be of greatest value to researchers and others interested in all the facts in a particular field.

The massive job of rewriting, participated in by panel participants, Commission members and staff members, is about finished. During this process, according to the Commission spokesman, the material twice was submitted to panel participants for their criticism, corrections or additions. Subsequently, he said, suggestions were evaluated by staff members and Commissioners, but there was not time to submit manuscripts of first volume chapters to participants.

From the start, those entrusted with writing and summarizing put a certain number of "suggested recommendations" into the material. Since mid-October, the Commission has been reviewing these "suggestions" along with the factual material, and reaching its own decisions on major and minor recommendations to be made in the final report.

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